Texas Centers for Infectious Disease Associates Pharmacy
FORT WORTH / 1025 College Ave., Fort Worth, TX 76104
Phone: 817-336-1640 Fax: 817-336-1643
DALLAS / 3410 Worth St., Ste. 780, Dallas TX 75246

Patient Information		Prescriber Information	
Patient name:		Prescriber name:	
DOB:	SSN:	DEA:	
Address:		NPI	License:
City:	State: Zip:	Address:	
Phone #:		City:	State: Zip:
Gender: ☐Male ☐Female ☐Other		Phone:	Fax:

Insurance Information: Complete entirely and fax front and back of patient's insurance card					
Primary Insurance	Subscriber	ID:	Name of insurer:		Phone:
Secondary Insurance	Subscriber	ID:	Name of insurer:		Phone:
Prescription card:	Name of insurer:	ID:	BIN:	PCN:	Group:

ICD 10 and Diagnosis:	Patient History	
ICD 10:	Weight ☐KG ☐LB	Height ☐IN ☐CM
Diagnosis:	☐NKDA ☐Allergies:	

Provider Orders:					
	Drug	Dose	Directions	QTY	Refills
MEDICATION	☐ Cimiza	☐ 200mg	☐ Induction ☐ weeks, 0, 2 and 4 ☐ Maintenance ☐ 200mg Q2weeks ☐ 400mg Q4weeks		
	☐ Remicade ☐ Inflectra	☐ 100mg vial	☐ infuse _____ (mg/kg) IV at weeks 0,2 and 6 then _____(mg/kg) Q_____weeks		
	☐ Stelara	☐130mg/26ml ☐ 45 mg PFS ☐ 90mg PFS	☐ induction dose: 1 syringe SQ on day 1, then 1 syringe on day 28 ☐ maintenance dose: 1 syringe SQ Q12weeks		
Pre-medication	☐Acetaminophen 325 mg PO ☐ Diphenhydramine 25 mg PO ☐ Diphenhydramine 25 mg IV ☐ Dexamethasone 4mg IVP ☐ Methylprednisolone 40mg IVP ☐ Other: _____				

LABS	
Baseline labs on admission and then drawn weekly while on therapy	☐CBC with differential ☐ CMP ☐ CRP Quant ☐ESR ☐CK ☐other: _____

Nursing: Evaluate and teach patient administration of IV medication, provide IV-line dressing change weekly and PRN, use SASH flushing protocol: S- Saline 10ml, A- administration medication, S- saline 10ml, H-Heparin 5ml (100units/ml). When on more than one dose per day patient to alternate lumens for administration

Prescriber Authorization: I authorize this pharmacy and its representative to act as my agent to secure coverage, dose IV meds based on labs and weight, provide supplies necessary for infusion and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent.

Prescriber signature: _____ Date: _____