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IV - Chronic Inflammatory Disease

Urgent/Stat Standard

Prescriber	Prescriber Information					
	Prescriber Name:			MD PA NP		
	NPI:		DEA:		Office Contact:	
	Address:					
City:	State:	Zip:	Phone #:		Fax #:	
Patient	Patient Information - Fax A Copy Of The Front And Back Of All Insurance Cards					
	First Name:		MI:	Last Name:		
	DOB:	Sex: M F	Last 4 Digits SSN :		Interpreter: Y N Specify:	
	Address:					
	City:	State:	Zip:	Primary #:		Alternate #:
Emergency Contact:		Phone #:		Contact Preference:	AM Noon PM	
Clinical	Clinical Information - Please Send Progress Notes, Lab Reports And Any Other Supporting Documents					
	Primary ICD10:		Secondary ICD10:		Diagnosis Date: / /	
	Weight: lb/ kg	Height: in/ cm	Allergies:			
	Current Medications:					
	Prior Therapies:					
	Continuity of Care: / /					
Prescription	Associated Clinical Info:					
	Prescription Information					
	Dose Start Date: / /		New Prescription	Refill Prescription	New to Therapy	Restarting Therapy
	Deliver to:	Prescriber's Office	Other	New	Refill	Dose Start Date: / /
	Drug	Strength	Directions		Refills	
	BENLYSTA®	Number of 120 mg/5ml vials:____ Number of 400 mg/20ml vials:____	Starter Dose: Infuse ____ mg IV over 1 hour at weeks 0, 2, and 4 Maintenance Dose: Infuse ____ mg IV over 1 hour once every 4 weeks		No Refills	
	ENTYVIO®	Number of 300 mg vials: ____	Starter Dose: Infuse 300mg IV over 30 minutes at weeks 0 and 2 Maintenance Dose: Infuse 300mg IV over 30 minutes once every 8 weeks beginning at week 6		No Refills	
	KRYSTEXXA®	Number of 8mg/ml vials: ____	Infuse 8mg IV over 2 hours every 2 weeks			
	ORENCIA®	Number of 250 mg vials: ____	Starter Dose: Infuse ____ mg IV in 100ml NS over 30 minutes at weeks 0 and 2 Maintenance Dose: Infuse ____ mg IV 100ml NS over 30 minutes at week 4 and every 4 weeks thereafter		No Refills	
	REMICADE®	Number of 100 mg vials: ____	Starter Dose: Infuse ____ mg IV over 2 hours at weeks 0, 2 and 6 Maintenance Dose: Infuse ____ mg IV over 2 hours once every ____ weeks		No Refills	
RIXUTAN®	Number of 100mg/10ml vials: ____ Number of 500mg/50ml vials: ____	Starter Dose: Infuse 1000 mg IV over 4-6 hours on day 1 and day 15 Maintenance Dose: Infuse 1000 mg IV over 4-6 hours every ____ weeks		No Refills		
SIMPONI ARIA®	Number of 50 mg/4ML vials: ____	Starter Dose: Infuse ____ mg IV over 30 minutes at weeks 0 and 4 Maintenance Dose: Infuse ____ mg IV over 30 minutes once every 8 weeks		No Refills		
STELARA®	Number of 45 mg/0.5ml vials: ____ Number of 90 mg/ml vials: ____ Number of 130 mg/26ml vials: ____	Starter Dose: Weight> 85kg: Infuse 520mg IV over 1 hour Weight 56kg-85kg: Infuse 390mg IV over 1 hour Weight< 55kg: Infuse 260mg IV over 1 hour Begin the SQ maintenance regimen 8 weeks after the initial IV dose		No Refills		

By signing this form and utilizing our services, you are authorizing Universal Specialty Pharmacy and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Sign	Prescriber Signature and Date (Required to validate prescription)	
	Physician Signature:	Date: / /

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