



Rx Order Form

Endocrinology

Fax Form to (626) 999-3236

Patient Information		Prescriber Information	
Patient Name: _____		Prescriber Name: _____	
Address: _____		Address: _____	
City, State, Zip: _____		City, State, Zip: _____	
Home Phone: _____		Phone: _____ Fax: _____	
Cell Phone: _____		DEA: _____ NPI: _____	
DOB: _____ Gender: ☐ M ☐ F		Contact Person: _____	
Weight: _____ lbs.	Allergies: ☐ NKDA ☐ Specify: _____		
Insurance Information			
(Please fax a copy of both sides for both pharmacy and medical cards)			
Primary Insurance: _____		ID#: _____	Group: _____
Secondary Insurance: _____		ID#: _____	Group: _____
Prescription Card: _____	ID#: _____	BIN#: _____	PCN#: _____ Group: _____
Diagnosis / ICD-10			
(Please fax relevant clinical notes, labs, tests, and previous medical history to expedite prior authorization)			
Primary Diagnosis: _____		ICD-10: _____	
Secondary Diagnosis: _____		ICD-10: _____	
Medication Order			
☐ Actemra® (tocilizumab)	☐ Lupkynis® (voclosporin)	☐ Simponi® (golimumab)	
☐ Benlysta® (belimumab)	☐ Olumiant® (baricitinib)	☐ Skyrizi® (risankizumab)	
☐ Cimzia® (certolizumab peg)	☐ Orencia® (abatacept)	☐ Sotyktu® (deucravacitinib)	
☐ Cosentyx® (secukinumab)	☐ Otezla® (apremilast)	☐ Stelara® (ustekinumab)	
☐ Enbrel® (etanercept)	☐ Prolia® (denosumab)	☐ Taltz® (Ixekizumab)	
☐ Evenity® (romosozumab)	☐ Purified Cortrophin® (corticotropin gel)	☐ Tepezza® (teprotumumab)	
☐ Forteo® (teriparatide)	☐ Rasuvo® (methotrexate)	☐ Tremfya® (guselkumab)	
☐ Gazyva® (obinutuzumab)	☐ Reclast® (zoledronic acid)	☐ Tymlos® (abaloparatide)	
☐ Humira® (adalimumab)	☐ Remicade® (infliximab)	☐ Uplizna® (inebilizumab-cdon)	
☐ Kevzara® (sarilumab)	☐ Rinvoq® (upadacitinib)	☐ Xeljanz® (tofacitinib)	
☐ IVIG (intravenous immunoglobulin)	☐ Rituxan® (rituximab)	☐ Other: _____	
☐ Krystexxa® (peglicase)	☐ Saphnelo® (Anifrolumab)		
Prescription Details			
☐ Loading	Dose: _____	Start Date: _____	
Route: ☐ SQ ☐ IV ☐ PO ☐	Frequency: _____	Quantity: _____	Refills: _____
☐ Maintenance	Dose: _____	Start Date: _____	
Route: ☐ SQ ☐ IV ☐ PO ☐	Frequency: _____	Quantity: _____	Refills: _____
IV pre-Meds (30-60min before infusion)			
☐ Acetaminophen _____ mg PO		☐ Methylprednisolone _____ mg ☐ PO ☐ IV	
☐ Diphenhydramine _____ mg ☐ PO ☐ IV		☐ Other: _____	
Clinical Information			
(Baseline Screening)			
☐ TB Test Completed	Date: _____	Result: ☐ Negative ☐ Positive	
☐ Hepatitis B Test Completed	Date: _____	Result: ☐ Negative ☐ Positive	
☐ G6PD deficiency (Krystexxa)	Date: _____	Result: ☐ Negative ☐ Positive	
Administration			
☐ Patient to self-administer	☐ Home Infusion Administration	☐ Office Administration	
Delivery			
☐ Ship to Patient	☐ Ship to Provider Office	☐ Other: _____	
By signing below, I certify that the above therapy is medically necessary and substitution is authorized unless noted otherwise.			
_____ Provider Signature		_____ Date	_____ Notes

120 N Fairway Ln Ste A, West Covina, CA 91791 | Ph: 626-999-3636 | Fax: 626-999-3236

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