TEXAS CENTERS FOR TCIDA INFECTIOUS DISEASE ASSOCIATES

DERMATOLOGY

☐ FORT WORTH / 1025 College Ave., Fort Worth, TX 76104
☐ DALLAS / 3410 Worth St., Ste. 790, Dallas TX 75246

TEL: ***817-336-1640*** FAX: ***817-336-1643***

PATIENT INFORMATION:			**PRESCRIBER INFORMATION:**		
Patient Name:			Prescriber Name:		
Address 1:			DEA:		
Address 2:			NPI:	License:	
City:	State:	Zip:	Address:		
Home Phone:	Alt:		City:	State:	Zip:
DOB: SSN: Gender: ☐ Male ☐ Female			Phone:	Fax:	
Language: ☐ English ☐ Spanish ☐ Other			POC:	Email	

INSURANCE INFORMATION: Complete entirely or fax front and back of patient's Insurance Cards

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:

CLINICAL INFORMATION: (Attach additional sheets if necessary)

ICD DIAGNOSIS CODE:	**PATIENT HISTORY:**
☐	Weight ☐ kg ☐ lb Height ☐ cm ☐ in
☐ Other:	☐ NKDA ☐ Allergies
Prior Therapy ☐ No ☐ Yes If Yes, Approximate End Date.	Comorbidities:
Reason for Discontinuance:	Concurrent Meds:

PRESCRIPTION INFORMATION:

Medication	Strength	Directions	Qty	Refills
☐ Cimzia™	☐ 200 mg	☐ Induction: ☐ weeks 0, 2 and 4. ☐ Maintenance: ☐ 200 mg every 2 weeks. ☐ 400 mg every 4 weeks.		
☐ Remicade™ ☐ Reflexis™ ☐ Inflectra™	☐ 100 mg Vial	☐ Infuse___(mg/kg IV at weeks 0, 2 and 6 then___mg/kg Q____weeks. Premeds:		
☐ Simponi™ (Only for PsA)	☐ 50 mg / 4 mL	☐ Infuse 50 mg once a month. ☐ 2 mg/kg weeks 0, 2 and 4 then every 8 weeks.		
☐ Stelera™	☐ 130 mg/26 mL ☐ 45 mg PFS ☐ 90 mg PFS	☐ Induction Dose: 1 syringe SQ on day 1, then 1 syringe on day 28		
		☐ Maintenance Dose Inject 1 syringe SQ every 12 weeks		
Pre-medications: ☐ Acetaminophen 325-650 mg PO ☐ Diphenhydramine 25-50 mg PO or IV ☐ Dexamethasone 4mg IVP ☐ Methylprednisolone 40 mg IVP				

Prescriber Authorization: I authorize this pharmacy and its representatives to act as my agent to secure coverage 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: _____