Rose Pharmacy
10008 Pines Blvd
Pembroke Pines, FL 33024
Phone: 888.797.4632 / 954.432.8290
Fax: 844.246.3364

ROSE INFUSIONS

Crohn's & Ulcerative Colitis Order Form

Today's Date: _____ Date Medication Needed: _____

Patient Information

Last Name: _____ First Name: _____

Date of Birth: _____ Social Security: _____ ❑Male ❑Female

Address: _____ City: _____ State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____

Diagnosis/ICD-10 Code:_____ Height / Weight / Allergies: _____

Insurance: _____ Policy #: _____ ***Please include copy of insurance card***

Rx Prescription:

Medication	Dose/Strength	Directions	Quantity	Refills
CIMZIA	❑PREFILLED SYSRINGES ❑ VIAL	❑Initial INJECT 400mg Sub-Q on Day 1, 14, &, 28 (qty 6)		
DUPIXENT®	❑ 300 mg/2 mL PFS ❑ 300 mg/2 mL Pen-Injector PF	❑Initial dose: Inject 600 mg SC (divided in two different injection sites) ❑Maintenance dose: Inject 300 mg SC every other week		
HUMIRA® **HUMIRA®CF**	❑Crohn's Starter Kit	INITIAL: Inject 160mg Sub-Q on Day 1, then 80mg on Day 14 (1 kit)		
	❑Pen ❑Pre-Filled Syringes	MAINTENANCE: Inject 40mg Sub-Q every other week (Qty 2)		
INFLECTRIS **REMICADE** **REMFLEXIS**	❑VIALS	INITIAL: Infuse_____mg IV at Day 0,14, &42 (qty___) MAINTENANCE: Infuse _____mg every 8 weeks (Qty___) Weight_____lbs/kg		
RINVOQ	❑tablets	INITIAL: TAKE ONE 45MG TABLET DAILY FOR 8 WEEKS MAINTENANCE: TAKE ONE 15MG TABLET DAILY		
SIMPONI	❑SMARTJEET PEN ❑PRE-FILLED SYRINGE	INITIAL 200MG SUB-Q ON DAY 1, THEN 100MG ON DAY 14 (QTY 3) ❑ MAINTENANCE: INJECT 100MG SUB-Q EVERY 4 WEEKS		
SKYRIZI	❑600MG/10ML ❑360MG/2.4ML PRE-FILLED SYRINGE CARTRIDGE VIA ON-BODY INJECTOR	❑Initial dose: INFUSE 600MG VIA IV AT WEEK 0,4, & 8 ❑Maintenance: INJECT 360MG SUB-Q 4 WEEKS AFTER FINAL INITIAL DOSE (WEEK 12) THEN EVERY 8 WEEKS THERE AFTER		
STELARA	❑130MG/26ML VIALS ❑PRE-FILLED SYRINGES ❑45MG VIALS	Sig:		
XELLENZ	❑5MG ❑10MG	Sig:		
ENTRYVIE	❑200MG STARTER KIT ❑200MG pfs kIT	Sig:		
OTHER:				

MD Signature:_____ Date:_____

MD Name (Printed):_____ NPI:_____ DEA:_____

Phone:_____ Fax:_____ Contact:_____

Address:_____ City:_____ State:_____ Zip:_____

Contact us with questions at: info@rosenursing.net
or call **887.797.4632** / **954.432.8290**

Fax completed form and all documentation to **844.246.3364**
All information contained in this form is strictly confidential and will become part of the patient's medical record.