



**Specialty Pharmacy Medications Statement of Medical Necessity**

Patient Name: _____	Physician Name: _____
Address: _____	Address: _____
City/St/Zip: _____	City/St/Zip: _____
Phone: _____	Phone: _____
MR: _____	Fax: _____
SS: _____	DOB: _____
	Pager: _____

The patient is being referred for education regarding (for those marked \* indicate medication from list below):

Anemia\*    Crohn's\*    Growth Hormone\*    Hepatitis C\*    Herbal Consult    Multiple Sclerosis\*    Rheumatoid Arthritis\*

Anemia	Growth Hormone	Hepatitis C	Multiple Sclerosis	Rheumatoid Arthritis
<b>Aranesp (darbopietin)</b> <input type="checkbox"/> 25mcg <input type="checkbox"/> 40mcg <input type="checkbox"/> 60mcg <input type="checkbox"/> 100mcg <input type="checkbox"/> 150mcg <input type="checkbox"/> 200mcg <input type="checkbox"/> 300mcg <input type="checkbox"/> 500 mcg <input type="checkbox"/> Other: _____  <input type="checkbox"/> Freq: _____  <b>ProCrit (erythropoietin)</b> <input type="checkbox"/> 40,000 IU <input type="checkbox"/> Other: _____  <input type="checkbox"/> Freq: _____	<b>Somatropin Product Name:</b> _____  <b>Dose:</b> _____ mg/kg  <b>Schedule:</b> <input type="checkbox"/> Daily <input type="checkbox"/> _____ per week <input type="checkbox"/> Weekly dosage divided equally 6-7 times per week  <b>Indication:</b> <input type="checkbox"/> Adult GHD <input type="checkbox"/> AIDS wasting <input type="checkbox"/> Chronic Renal Insuff <input type="checkbox"/> Idiopathic Short Stature <input type="checkbox"/> Prader-Willi Syndrome <input type="checkbox"/> Pediatric GHD <input type="checkbox"/> SBS <input type="checkbox"/> Small for Gestational Age <input type="checkbox"/> Turner Syndrome	<b>Genotype:</b> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4  <b>Pegasys (peginterferon alfa-2a)</b> <input type="checkbox"/> 180mcg weekly <input type="checkbox"/> Other: _____  <b>PEG-Intron (peginterferon alfa-2b)</b> <input type="checkbox"/> 50mcg/0.5mL <input type="checkbox"/> 80mcg/0.5mL <input type="checkbox"/> 120mcg/0.5mL <input type="checkbox"/> 150mcg/0.5mL <input type="checkbox"/> Other: _____  <b>Copegus/Rebetol (ribavirin)</b> <input type="checkbox"/> 400mg AM/ 600mg PM <input type="checkbox"/> 600mg AM/ 600mg PM <input type="checkbox"/> Other: _____	<b>Avonex (IM betainterferon-1a)</b> <input type="checkbox"/> 30mcg/0.5mL weekly <input type="checkbox"/> Other: _____  <b>Betaseron (betainterferon-1b)</b> <input type="checkbox"/> 0.0625mg (0.25mL) <input type="checkbox"/> 0.125mg (0.5mL) <input type="checkbox"/> 0.1875mg (0.75mL) <input type="checkbox"/> 0.25mg (1mL)  <b>Copaxone (glatiramir)</b> <input type="checkbox"/> 20mg/mL daily  <b>Rebif (SQ betainterferon-1a)</b> <input type="checkbox"/> 8.8mcg/0.2mL 3x/wk <input type="checkbox"/> 22mcg/0.5mL 3x/wk <input type="checkbox"/> 44mcg/0.5mL 3x/wk	<b>Enbrel (etanercept)</b> <input type="checkbox"/> 50mg q weekly <input type="checkbox"/> Other: _____  <b>Humira (adalimumab)</b> <input type="checkbox"/> 40mg q other week <input type="checkbox"/> Other: _____  <b>Kineret (anakinra)</b> <input type="checkbox"/> 100mg every day <input type="checkbox"/> Other: _____  <b>Methotrexate</b> <input type="checkbox"/> Dose: _____  <input type="checkbox"/> Freq: _____  <input type="checkbox"/> SQ <input type="checkbox"/> IM

Indicate duration of therapy:  12 weeks    24 weeks    48 weeks    Chronic    Other: \_\_\_\_\_

Analgesic prior to inject:  Yes    No        **If yes:**  \_\_\_\_\_ mg IBU or  \_\_\_\_\_ mg APAP

**I am referring the patient to the Clinical Partners Specialty Pharmacy Medications Education Service to provide the following:**

- Educate the patient on sterile preparation of above indicated physician prescribed products for injection.
- Teach the patient how to perform self-administration of the above indicated medication via the SC/IM route.
- Reinforce education about potential side effects associated with the medication(s) listed above and the importance of avoiding pregnancy through the duration of treatment.
- Patient may practice self-injection of preservative-free normal saline for injection, USP for education purposes.

**I authorize The Ohio State University, College of Pharmacy, Clinical Partners Program to see the patient 1-2 TIMES to provide this self-medication education. I consider this program to be a necessary part of this patient's medical care.**

\_\_\_\_\_  
(Physician/APN signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Pharmacist signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Patient signature)

\_\_\_\_\_  
(Date)

**Pharmacy Use**

Appt date/time: \_\_\_\_\_