RHEUMATOLOGY

FAX: 725.228.5220

☐ New Prescription/Referral
☐ Prescription Refill

eMediate INFUSION

 # Of Refills:

PATIENT INFORMATION

*Please attach the copy of patient insurance & ID (front and back)

Name:	DOB:	Weight: kg

PHYSICIAN INFORMATION

Prescriber Name:	Phone:	Fax:
Office Contact:	*Email (for the referral update):	
Clinic:	Address:	
NPI:		
Patient's PCP Name:	Phone:	Fax:
Clinic:	Address:	
NPI:		

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Actemra (tocilizumab)

☐ 4mg/kg IV every 4 weeks for_____ doses then followed by 8mg/kg every 4 weeks thereafter
☐ 4mg/kg IV every 4 weeks ☐ 8mg/kg IV every 4 weeks ☐ Other dose: _____mg/kg IV every 4 weeks

Cimzia (Certolizumab pegol)

☐ Initial Dose: 400mg SubQ injection at weeks 0, 2, and 4 weeks
☐ Maintenance Dose: ☐ 200mg Subcutaneously Q 2 weeks **OR** ☐ 400mg subcutaneously Q 4 weeks

Krystexxa (pegloticase)

☐ 8mg via IV infusion for at least 120mins Q2wks on a 250ml NS at room temperature
☐ Observe for 1 hour after infusion ☐ Discontinue treatment if uric acid level to > 6mg/dL

IVIG

☐ Ok to use biosimilar

☐ **Gamunex (10%)** ☐ **Privigen (10%)** ☐ **Octagam (10%)** ☐ **Gammaplex (10%)**
☐ **Gammagard (10%)** ☐ **Bivigam (10%)** ☐ **Gammaked(10%)** ☐ **Flebogamma DIF (10%)**
☐ **Asceniv (10%)** ☐ **Panzyga (10%)** ☐ Other Orders:_____

Dosage: ☐ _____g/day ☐ _____g/kg ☐ Over _____# of days ☐ _____# of months

Frequency: ☐ One-Time Only ☐ every _____ weeks (Optional: Start Date _____)

Orencia (abatacept)

Dosage: _____ mg/kg IV

Frequency: ☐ Every 4 weeks OR ☐ 0, 2, 4 weeks, and every 4 weeks thereafter

Stelara (ustekinumab)

☐ Initial Dose: ☐ 45mg SubQ at weeks 0, 4, and every 12 weeks thereafter
☐ 90mg SubQ at weeks 0, 4, and every 12 weeks thereafter
☐ Maintenance Dose: ☐ 45mg SubQ every 12 weeks ☐ 90mg SubQ every 12 weeks

Simponi Aria (golimumab)

☐ Initial Dose: 2mg/kg at weeks 0, 4, and then every 8 weeks
☐ Maintenance Dose: 2mg/kg every 8 weeks

Infliximab

☐ Ok to use biosimilar

☐ **Remicade** ☐ **Inflectra** ☐ **Renflexis** ☐ **Avsola**

Dosage: _____ mg/kg IV

Frequency: ☐ 0, 2, 6, then every 8 weeks ☐ Every _____ weeks
☐ Other: _____

Rituximab

☐ Ok to use biosimilar

☐ **Rituxan** ☐ **Ruxience** ☐ **Riabni** ☐ **Truxima**

Dosage: ☐ 1000mg ☐ 500mg ☐ Other: _____
☐ 375mg/m2

Frequency: ☐ one time dose ☐ Weekly x 4 weeks ☐ Other:_____
☐ Repeat dose in 2 weeks ☐ Repeat after 6 months

☐ Other Orders:_____

Saphnelo (anifrolumab-fnia)

☐ 300mg IV every 4 weeks

Pre-Medication:

☐ Solumedrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Others: _____

☐ Tylenol _____ mg PO
☐ 650 mg ☐ 975 mg ☐ 1000mg

☐ Benadryl _____ mg PO
☐ 25 mg ☐ 50 mg
☐ IV ☐ PO

ANA Kit Protocol:

☐ OK to use

Dx: Diagnosis_____ **ICD-10:** _____

PRESCRIBER SIGNATURE: x Date (Valid for 1 year):

I authorize eMediate Infusion Center, PLLC , Assist Point Clinical or its authorized representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to eMediate Infusion Center.

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PATIENT INFORMATION

Name: | DOB:

REQUIRED INFORMATION (please attach)

☐ **Patient demographics** ☐ **Insurance attached** ☐ **Diagnosis(supporting)** ☐ **History & Physical**

☐ **Lab Results** ☐ **Clinical progress notes** ☐ **Medication list** ☐ **Other Test Results**

☐ Baseline creatinine: (Required for: IVIG) ☐ Uric Acid: (Required: Krystexxa)

☐ Serum immunoglobulins: (Rituximab)

☐ Hep B core antibody total(not IgM): (Required for: Rituximab)

☐ Hep B surface antigen: (Required for: Actemra, Cimzia, Infliximab, Rituximab, Simponi Aria)

☐ TB Results within 12 months: (Required: Actemra, Cimzia, Infliximab, Stelara, Simponi Aria, Orencia)

***If TB or Hep B results are positive - please provide documentation of treatment or medical clearance & a negative CXR (TB+)**

We can do patient teaching for IV/IM/SQ injections if needed. One time or multiple visits. If insurance allows we can also administer SQ/IM shot