RHEUMATOLOGY

*Patient Insurance & ID (front and back) are needed

☐ New Prescription/Referral
☐ Prescription Refill

Of Refills:

Rx: Patient Name: | Patient Weight: kg | DOB:

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 IV ☐ _____g/kg IV ☐ 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

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

ANA Kit Protocol:
☐ OK to use

Dx: ICD-10:
Diagnosis:

Physician Signature | NPI #: | DATE:(Valid for 1 year)

By affixing my signature, I confirm the medical necessity of the aforementioned therapy, products, and services, as well as my responsibility for the patient's care. I have obtained consent to disclose the mentioned details and any relevant medical or patient information concerning this treatment. I grant the pharmacy permission to contact the insurance company on my behalf to secure authorization for the patient.

PHYSICIAN INFORMATION

Physician Name: | Clinic:

Phone: Fax: Email: Other:

Office Mailing Address:

Please include the following
☐ Patient demographics ☐ Insurance attached ☐ Diagnosis(supporting) ☐ History & Physical
☐ Lab Results ☐ Clinical progress notes ☐ Medication list ☐ Other Test Results

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

*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.