RHEUMATOLOGY

☐ 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%)**

Dosage: ☐ _____gm/day ☐ _____mg/kg ☐ _____# 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.