

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____

Patient Weight: _____ lbs. (required) Address: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy ☐ Next Treatment Date: _____

DIAGNOSIS

- | | |
|---|---|
| ☐ Rheumatoid Arthritis, <i>unspecified</i> | ☐ Wegener's Granulomatosis |
| ☐ Unspecified Iridocyclitis | ☐ Ankylosing Spondylitis, <i>unspecified</i> |
| ☐ Arthropathic Psoriasis, <i>unspecified</i> | ☐ Gout |
| ☐ Rheumatoid Arthritis with Rheumatoid Factor, <i>unspecified</i> | ☐ Systemic Lupus Erythematosus |
| ☐ Rheumatoid Arthritis without Rheumatoid Factor, <i>unspecified</i> | ☐ Other: _____ |

ICD-10 Code: _____

THERAPY ORDER

MEDICATION	ORDERS	REFILLS	PRE-MEDICATIONS	LAB ORDERS
☐ Actemra	☐ 4 mg/kg IV every 4 weeks for _____ doses, then followed by 8mg/kg every 4 weeks thereafter ☐ 4 mg/kg IV every 4 weeks **Dose not to exceed 800mg in RA/CRS** ☐ 8 mg/kg IV every 4 weeks **Dose not to exceed 600mg in GCA** ☐ _____ mg IV every 4 weeks	☐ _____	☐ Acetaminophen 500mg PO Please choose one antihistamine: ☐ Diphenhydramine ☐ 25mg PO ☐ 50mg PO ☐ Loratadine 10mg PO ☐ Cetirizine 10mg PO	☐ TB Screening Test* ☐ Actemra ☐ Cimiza ☐ Infliximab ☐ Stelara ☐ Simponi Aria ☐ Orencia ☐ Positive ☐ Negative ☐ Hep. B Screening (Hep. B surface antigen) ☐ Actemra ☐ Cimiza ☐ Infliximab ☐ Rituximab ☐ Simponi Aria ☐ Positive ☐ Negative ☐ Hep. B Core Antibody Total (not IgM) ☐ Rituximab ☐ Positive ☐ Negative ☐ Serum Immunoglobulins ☐ Rituximab ☐ Positive ☐ Negative ☐ Baseline Creatinine ☐ IVig ☐ Positive ☐ Negative
☐ Cimzia	Initial Dose: ☐ 400mg subQ at weeks 0, 2, and 4 weeks Maintenance: ☐ 200mg subQ 2 weeks OR ☐ 400mg subQ 4 weeks	☐ _____		
☐ Immunoglobulin	☐ IV ☐ SubQ _____ gm/kg x _____ day(s) OR divided over _____ day(s) _____ mg/kg x _____ day(s) OR divided over _____ day(s) Frequency: Every _____ weeks or _____ weeks or _____ Brand: _____	☐ _____		
☐ Infliximab	Dose: _____ mg/kg ☐ May substitute biosimilar per insurance requirement Frequency: ☐ Every _____ weeks ☐ 0, 2, 6, then every 8 weeks ☐ Do not substitute. Brand: _____ For internal use only: Brand: _____	☐ _____		
☐ Krystexxa	☐ 8mg IV every 2 weeks	☐ _____		
☐ Orencia	Dose: _____ mg IV Frequency: ☐ Every 4 weeks ☐ 0, 2, 4 weeks, and every 4 weeks thereafter	☐ _____	Additional Pre-medications: ☐ Solu-Medrol _____mg IVP ☐ Solu-Cortef _____mg IVP ☐ Other: _____	
☐ Rituximab	Dose: ☐ 1000mg ☐ 375mg/m ² ☐ May substitute biosimilar per insurance requirement For internal use only: Brand: _____ Frequency: ☐ Do not substitute. Brand: _____ ☐ One Time Dose ☐ Day 0, repeat dose in 2 weeks ☐ Weekly x 4 weeks	☐ _____		
☐ Saphnelo	☐ 300mg IV every 4 weeks	☐ _____		
☐ Simponi Aria	Initial Dose: ☐ 2mg/kg at weeks 0, 4 and then every 8 weeks Maintenance: ☐ 2mg/kg every 8 weeks	☐ _____		
☐ Stelara	Initial Dose: ☐ 45mg subQ initially, 4 weeks later, followed by 45mg every 12 weeks ☐ 90mg subQ initially, 4 weeks later, followed by 90mg every 12 weeks Maintenance: ☐ 45mg subQ every 12 weeks ☐ 90mg subQ every 12 weeks	☐ _____		*If TB or Hepatitis B results are positive - please provide documentation of treatment or medical clearance, and a negative CXR (TB+)

PROVIDER INFORMATION

Provider Name: _____ Date: _____

NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

PRESCRIBER SIGNATURE

Prescriber's Signature: _____

Date: _____