ALLIED INFUSION SERVICES

Rheumatology Infusion Orders

Phone: 713-222-2364 or 1-888-538-0060
Fax: 832-698-3961

Patient Information

Name: ______________________
DOB: ______________________
Address: ______________________
City: ____________ State: ____________
Zip: ____________ Weight: ____________
Phone: ______________________
Allergies: ______________________

Prescriber Information

Prescriber Name: ______________________
NPI: ______________________
Address: ______________________
City: ______________________
State: ____________ Zip: ____________
Phone: ______________________

☐ Infliximab (Remicade) ☐ Infliximab-axxq (Avsola) ☐ Infliximab-dyyb (Inflectra) ☐ Infliximab-abda (Renflexis) ☐ Simponi Aria
☐ Orencia ☐ Benlysta ☐ Saphnelo ☐ Actemra ☐ Evenity ☐ Prolia ☐ Reclast ☐ Rituxan ☐ Truxima ☐ Ruxience ☐ Krystexxa

Diagnosis (please provide ICD-10 code in space provided):

____ Rheumatoid Arthritis ____ Ankylosing Spondylitis ____ Psoriatic Arthritis ____ Plaque Psoriasis ____ Lupus ____ Gout
____ Granulomatosis with Polyangiitis ____ Microscopic Polyangiitis ____ Polyarticular Juvenile Idiopathic Arthritis
Other: ______________________

Nursing Orders: Hold infusion and notify provider for:
Signs/symptoms of illness or active infection, planned/recent surgical procedures, cough, night sweats, unintended weight loss, recent live vaccinations, active shingles.
If infusion related reaction occurs, stop infusion and follow Hypersensitivity Reaction Management Policy/Protocol as clinically indicated

Premedications:

☐ Tylenol 650mg PO ☐ Loratadine 10mg PO ☐ Benadryl 25mg IV or PO ☐ Solu-Medrol 40mg, 125mg or ____ mg
☐ Other: ______________________

Order valid for one year unless otherwise indicated. IV solutions and diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.

Medication	Orders
☐ Evenity 210 MG SQ	☐ Every month for 12 months Inject two 105MG/1.17 ML prefilled syringes of Evenity
☐ Prolia 60 MG SQ	☐ Every 6 Months for 1 year Inject one 60 MG prefilled syringe of Prolia
☐ Reclast 5 MG IV	☐ Once a year
☐ Remicade ☐ Avsola ☐ Inflectra ☐ Renflexis IV	_______mg/kg ☐ Weeks 0, 2, and 6, then every __________ weeks ☐ Every _________ weeks Mixed in 250 mL (or 500 mL for doses exceeding 1000mg) 0.9% sodium chloride. Use in-line, sterile, non-pyrogenic low protein binding filter (pore size 1.2 micron or less).
☐ Benlysta IV	10 mg/kg ☐ Weeks 0, 2, 4 then every 4 weeks ☐ Every 4 weeks Mixed in 250 mL 0.9% sodium chloride. Use in-line, sterile, non-pyrogenic low protein binding filter (pore size 1.2 micron or less).
☐ Actemra IV	☐ 4 mg/kg ☐ 8 mg/kg ☐ Weeks 0, 4, and then every 4 weeks ☐ Every 4 weeks Mixed in 100 mL 0.9% sodium chloride. Use in-line, sterile, non-pyrogenic low protein binding filter (pore size 1.2 micron or less).

☐ Simponi Aria IV	2 mg/kg ☐ Weeks 0, 4, and then every 8 weeks ☐ Every 8 weeks Mixed in 100 mL 0.9% sodium chloride. Use in-line, sterile, non-pyrogenic low protein binding filter (pore size 1.2 micron or less).
☐ Orencia IV	____ mg ☐ Weeks 0, 2,4 and then every 4 weeks ☐ Every 4 weeks Mixed in 100 mL 0.9% sodium chloride. Use in-line, sterile, non-pyrogenic low protein binding filter (pore size 1.2 micron or less).
☐ Saphnelo 300 MG IV	☐ Every 4 weeks Mixed in 100 mL 0.9% sodium chloride. Use in-line, sterile, non-pyrogenic low protein binding filter (pore size 1.2 micron or less).
☐ Krystexxa IV 8 MG	☐ Every 2 weeks Use in-line, sterile, non-pyrogenic low protein binding filter (pore size 1.2 micron or less).
☐ Rituxan ☐ Truxima ☐ Ruxience IV	☐ 1000 mg or ____ mg ☐ Weeks 0, 2, and every 24 weeks ☐ 375 mg/m^2 once a week for 4 consecutive weeks Mixed in 500 mL 0.9% sodium chloride. Use in-line, sterile, non-pyrogenic low protein binding filter (pore size 1.2 micron or less).

Prescriber Name (Please print): ______________________________

Prescriber Signature: ______________________________ Date: ______________

Please include a copy of the latest insurance information as well as all applicable clinical notes.

Email to: orders@alliedinfusion.com Fax to: 832-698-3961

By signing this form, you certify that the use of the selected treatment is medically necessary and you will be supervising the treatment of the patient. Additionally, you authorize Allied Infusion Services to act as your prior authorization designated agent when interacting with medical and prescription payors and patient assistance programs.