



Patient Information	Prescriber Information
Name: _____	Prescriber Name: _____
DOB: _____	NPI: _____
Address: _____	Address: _____
City: _____ State: _____	City: _____
Zip: _____ Weight: _____	State: _____ Zip: _____
Phone: _____	Phone: _____
Allergies: _____	

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.

<input type="checkbox"/> Simponi Aria IV	2 mg/kg <input type="checkbox"/> Weeks 0, 4, and then every 8 weeks <input type="checkbox"/> 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).
<input type="checkbox"/> Orencia IV	_____ mg <input type="checkbox"/> Weeks 0, 2,4 and then every 4 weeks <input type="checkbox"/> 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).
<input type="checkbox"/> Saphnelo 300 MG IV	<input type="checkbox"/> 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).
<input type="checkbox"/> Krystexxa IV 8 MG	<input type="checkbox"/> Every 2 weeks Use in-line, sterile, non-pyrogenic low protein binding filter (pore size 1.2 micron or less).
<input type="checkbox"/> Rituxan <input type="checkbox"/> Truxima <input type="checkbox"/> Ruxience <div style="text-align: right;">IV</div>	<input type="checkbox"/> 1000 mg or _____ mg <input type="checkbox"/> Weeks 0, 2, and every 24 weeks <input type="checkbox"/> 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).
<input type="checkbox"/> Actemra IV	<input type="checkbox"/> 4 mg/kg <input type="checkbox"/> 8 mg/kg <input type="checkbox"/> Weeks 0, 4, and then every 4 weeks <input type="checkbox"/> 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).

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