



Patient Information	
Name:	<input type="text"/>
DOB:	<input type="text"/>
Address:	<input type="text"/>
City:	<input type="text"/>
State:	<input type="text"/>
Zip:	<input type="text"/>
Weight:	<input type="text"/>
Phone:	<input type="text"/>
Allergies:	<input type="text"/>

Prescriber Information	
Prescriber Name:	<input type="text"/>
NPI:	<input type="text"/>
Address:	<input type="text"/>
City:	<input type="text"/>
State:	<input type="text"/>
Zip:	<input type="text"/>
Phone:	<input type="text"/>

Diagnosis (please provide ICD-10 code in space provided):	
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Ankylosing Spondylitis
<input type="checkbox"/> Psoriatic Arthritis	<input type="checkbox"/> Plaque Psoriasis
<input type="checkbox"/> Lupus	<input type="checkbox"/> Gout
<input type="checkbox"/> Granulomatosis with Polyangiitis	<input type="checkbox"/> Microscopic Polyangiitis
<input type="checkbox"/> Polyarticular Juvenile Idiopathic Arthritis	
Other: <input type="text"/>	

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:	
<input type="checkbox"/> Tylenol 650mg PO	<input type="checkbox"/> Loratadine 10mg PO
<input type="checkbox"/> Benadryl 25mg IV or PO	<input type="checkbox"/> Solu-Medrol 40mg, 125mg or <input type="text"/> mg
<input type="checkbox"/> Other: <input type="text"/>	
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"/> Evenity 210 MG SQ	<input type="checkbox"/> Every month for 12 months Inject two 105MG/1.17 ML prefilled syringes of Evenity
<input type="checkbox"/> Jubbonti 60MG SQ	<input type="checkbox"/> Every 6 Months for 1 year Inject one 60 MG prefilled syringe of Jubbonti
<input type="checkbox"/> Reclast 5 MG IV	<input type="checkbox"/> Once a year
<input type="checkbox"/> Remicade <input type="checkbox"/> Avsola <input type="checkbox"/> Inflectra <input type="checkbox"/> Renflexis IV	<input type="text"/> mg/kg <input type="checkbox"/> Weeks 0, 2, and 6, then every <input type="text"/> weeks <input type="checkbox"/> Every <input type="text"/> 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).
<input type="checkbox"/> Benlysta IV	10 mg/kg <input type="checkbox"/> Weeks 0, 2, 4 then every 4 weeks <input type="checkbox"/> 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).

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