



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

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

Drug	Dosing
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 ☐ May substitute biosimilar per insurance requirement ☐ 8mg/kg IV every 4 weeks Allied use only. Brand: ☐ Other Dose: mg IV every 4 weeks ☐ Do not substitute. Brand:
Cimzia (certolizumab pegol)	☐ Initial Dose: 400mg SubQ at weeks 0, 2, and 4 weeks Maintenance Dose: ☐ 200mg SubQ Q 2 weeks OR ☐ 400mg SubQ Q 4 weeks
Immunoglobulin	☐ IV ☐ SubQ gm/kg x day(s) OR divided over day(s) Brand: mg/kg x day(s) OR divided over day(s) (Allied to choose if not indicated) Frequency: Every weeks or
Infliximab	Dose: mg/kg ☐ May substitute biosimilar per insurance requirement Frequency: ☐ 0, 2, 6, then every 8 weeks Allied use only. Brand: ☐ Every weeks ☐ Do not substitute. Brand:
Krystexxa (pegloticase)	☐ 8mg IV every 2 weeks
Orencia (abatacept)	Orencia Dose: mg IV Frequency: ☐ 0, 2, 4 weeks, and every 4 weeks thereafter OR ☐ Every 4 weeks
Rituximab	Dose: ☐ 1000mg ☐ 375mg/m ² ☐ May substitute biosimilar per insurance requirement Frequency: ☐ One time dose ☐ weekly x4 Allied use only. Brand: ☐ Day 0, repeat dose in 2 weeks ☐ Do not substitute. Brand: Other:
Saphnelo (anifrolumab)	☐ 300mg IV every 4 weeks
Simponi Aria (golimumab)	☐ Initial Dose: 2mg/kg at weeks 0, 4, and then every 8 weeks ☐ Maintenance Dose: 2mg/kg every 8 weeks
Stelara (Ustekinumab)	☐ 45mg SubQ initially, 4 weeks later, followed by 45mg every 12 weeks ☐ 90mg SubQ initially, 4 weeks later, followed by 90mg every 12 weeks ☐ 45mg SubQ every 12 weeks ☐ May substitute biosimilar per insurance requirement ☐ 90mg SubQ every 12 weeks Allied use only. Brand: ☐ Do not substitute. Brand:

Premedications:

☐ Tylenol 650mg PO
 ☐ Benadryl 25mg IV or PO
 ☐ Solu-Medrol IV 40mg, 125mg or mg

☐ Other: IV or PO

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.

Prescriber Name (Please print): Contact Person:

Prescriber Signature: Date:

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