



Patient Information

Patient Name: _____ DOB: _____ Height: _____ Weight: _____ Patient Contact #: _____

Medical Assessment

Please Attach a Demographics Page & Copy of Insurance Card with this Prescription if Available:

1. **Diagnosis:** M06.9 Rheumatoid Arthritis L40.50 Psoriatic Arthritis M45. __ Ankylosing Spondylitis Other: _____
 M45.A0 Non-radiographic axial spondylarthritis of unspecified sites in the spine
 M32.10 Systemic lupus erythematosus M1A. __ 0 Chronic gout M10. __ Idiopathic gout
2. **Drug Allergies:** _____
3. **Failed Medications:** Methotrexate Therapy Length: _____ Discontinuation Reason: _____
 _____ Therapy Length: _____ Discontinuation Reason: _____
4. **Negative TB Skin Test (PPD Test):** Yes No When: _____ (Please Attach)

****Please include a demographics page, front and back of an insurance card, any clinical notes with supporting diagnosis, lab-work, tests, and any other supporting documentation including past tried and / or failed therapies associated with diagnosis****

Labwork: _____ To be Drawn by: Infusion Clinic Referring Provider

Pre-Medication Orders:

- APAP 325mg 500mg 650mg - PO 30 minutes before infusion.
- Diphenhydramine 25mg 50mg – PO 30 minutes before infusion.
 25mg IVP 50mg IVP
- Alternate Oral Antihistamines: Cetirizine 10mg Loratadine 10mg Fexofenadine 60mg or 180mg
- Methylprednisolone 40mg IVP 125mg IVP or other _____ mg IVP
- Famotidine 20mg PO 40mg PO 20mg IVP 40mg IVP
- Ondansetron 4 mg IVP 4 mg PO

Medication

Actemra (tocilizumab)

Dosage: Actemra per 100ml sodium chloride 0.9% IV to infuse over at least 1 hour.

Frequency:

- Induction Dosage of 4 mg / kg
- Maintenance Dosage of 4 mg / kg or 8mg / kg every 4 weeks

Maintenance Refills: _____

Benlysta (belimumab)

Dosage: Benlysta 10mg / kg per 250ml sodium chloride 0.9% IV to infuse over at least 60 minutes

Frequency:

- Induction orders to be completed at 0,2,and 4 weeks (10mg / kg)
- Maintenance orders every 4 weeks (10mg / kg)

Maintenance Refills: _____

Cosentyx (secukinumab)

- With Induction Dosage: 6mg / kg IV (_____ mg) at week 0, followed by 1.75mg / kg (_____ mg) every 4 weeks thereafter (max maintenance dose of 300mg per infusion)
- Without Induction Dose: 1.75mg / kg IV (_____ mg) every 4 weeks thereafter (max maintenance dose of 300mg per infusion)

Maintenance Refills: _____

Krystexxa (pegloticase)

Dosage:

- 8 mg per 250 ml sodium chloride 0.9% IV to infuse over at least 2 hours every 2 weeks

**** Pre-medications of diphenhydramine IVP and methylprednisolone is recommended prior to infusion****

Maintenance Refills: _____

Physician Prescription Orders Address: _____ Phone: _____

Fax: _____ Clinic Contact: _____ Physician Name: _____

NPI # _____ **Physician Signature:** _____ **Date:** _____