RELIANT SPECIALTY INFUSION

AIC Rheumatology #2 **Fax: 833-808-0833**

Patient Information

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

Medical Assessment

1. **Diagnosis:** ☐ M06.9 Rheumatoid Arthritis ☐ L40.50 Psoriatic Arthritis ☐ Ankylosing Spondylitis ☐ Other: _____
   ☐ 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: _____

****Please include a demographics page, front and back of an insurance card-medical / RX insurance, 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

Infliximab (Remicade & Biosimilars)

- ❑ ***Preferred*** **- Infusion Clinic Preference (Remicade / Avsola / Inflectra / Renflexis) based on payer directives / availability**
- ❑ **Specific Product:** _____

Dosage:

- ❑ 3 mg /kg per 250 ml sodium chloride 0.9% IV to infuse over at least 2 hours, or
- ❑ Other Dosage: ____mg or ___mg / kg per 250-500ml sodium chloride 0.9% IV

Frequency:

- ❑ Induction orders to be completed at week 0, 2, and 6 weeks and then every 8 weeks thereafter
- ❑ Orders every 8 weeks (maintenance)
- ❑ Other orders: _____ **Maintenance Refills**: ___

Orencia (abatacept)

Dosage: Orencia dosage per 100ml sodium chloride 0.9% IV to infuse over at least 30 minutes.
☐ 500mg 750mg ☐ 1000mg

Frequency: __

- ❑ Induction orders to be completed at 0 week, 2 week, and 4 weeks, and then every 4 weeks thereafter
- ❑ Maintenance orders every 4 weeks **Maintenance Refills**: ___

Rituximab (Rituxan & Biosimilars)

- ❑ ***Preferred*** **- Infusion Clinic Preference (Rituxan / Ruxience / Truxima) based on payer directives / availability**
- ❑ **Specific Product:** _____

Dosage: 1000mg IV per 500ml sodium chloride 0.9% to infuse per protocol.

Frequency:

- ❑ Infuse at 0 week and 2 weeks every 4 months (16 weeks) -or-
- ❑ Infuse at 0 week and 2 weeks every 6 months (24 weeks)
- ❑ Other orders: _____ **Maintenance Refills**: ___

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

Physician Prescription Orders

Address: _____ Phone: _____

Fax: _____ Clinic Contact: _____ Physician Name: _____

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