RELIANT SPECIALTY INFUSION

AIC Rheumatology #3 **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: _____
4. **Negative TB Skin Test (PPD Test):** ☐ Yes ☐ No When: _____ (Please Attach)

****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 by 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

Saphnelo (anifrolumab-fnia)

Dosage / Frequency:

- ❑ Saphnelo 300mg per 100 ml sodium chloride 0.9% IV to infuse over 30 minutes every 4 weeks via pump with 0.2 or 0.22-micron filter.
- ❑ **Maintenance Refills**: ___

Stelara (ustekinumab) – *Induction / Maintenance dosage administered SQ in AIC / HCP office only*

Dosage / Frequency:

Induction:

- ❑ Stelara 45mg SQ injection at 0 week, 4 week, and then every 12 weeks
- ❑ Stelara 90mg SQ injection at 0 week, 4 week, and then every 12 weeks

Maintenance:

- ❑ Stelara 45mg SQ injection every 12 weeks.
- ❑ Stelara 90mg SQ injection every 12 weeks
- ❑ **Maintenance Refills**: ___

Simponi Aria (golimumab)

Dosage: Simponi Aria 2 mg / kg per 100ml sodium chloride 0.9% IV to infuse over at least 30 minutes.

Frequency:

- ❑ Induction: Orders to be completed at 0 week and 4 weeks, and then every 8 weeks thereafter
- ❑ Maintenance: Orders to be completed every 8 weeks.
- ❑ Other: _____
- ❑ **Maintenance Refills**: ___

Physician Prescription Orders

Address: _____ Phone: _____

Fax: _____ Clinic Contact: _____ Physician Name: _____

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