

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 OR 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 / Frequency:

- ☐ Induction: 4 mg / kg at week 0
- ☐ Maintenance: ☐ 4 mg / kg or ☐ 8mg / kg at week 4 and every 4 weeks thereafter
- ☐ **Maintenance Refills:** _____

Benlysta (belimumab)

Dosage / Frequency:

- ☐ Induction: 10mg/kg at 0, 2, and 4 weeks
- ☐ Maintenance: 10 mg/kg at week 8 and every 4 weeks thereafter
- ☐ **Maintenance Refills:** _____

Cosentyx (secukinumab)

- ☐ With Induction: 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: 1.75mg / kg IV (_____ mg) every 4 weeks thereafter (max maintenance dose of 300mg per infusion)
- ☐ **Maintenance Refills:** _____

Krystexxa (pegloticase)

Dosage:

- ☐ 8 mg every 2 weeks
- ☐ **Maintenance Refills:** _____

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

Physician Prescription Orders Address: _____ Phone: _____

Fax: _____ Clinic Contact: _____ Physician Name: _____

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