

PATIENT INFORMATION:

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:** _____

DIAGNOSIS AND ICD-10 CODE:

- ☐ M06.9 - Rheumatoid Arthritis, Unspecified ☐ M05.9 - w/Rheumatoid Factor ☐ M06.00 - w/out Rheumatoid Factor
☐ M45.9 - Ankylosing Spondylitis, Unspecified ☐ L40.50 - Arthropathic Psoriasis, Unspecified ☐ M10.9- Gout
☐ M32.9 - Systemic Lupus Erythematosus ☐ H20.9 - Unspecified Iridocyclitis ☐ M31.3 – Granulomatosis w/Polyangiitis
☐ Other diagnoses: _____

PRESCRIPTION:

- ☐ **Actemra:** ☐ 4mg/kg IV every 4 weeks for _____ doses, then followed by 8mg/kg every 4 weeks thereafter
☐ 4mg/kg IV every 4 weeks ☐ 8mg/kg IV every 4 weeks ☐ Other dose: _____ mg/kg every 4 weeks
- ☐ **Cimzia:** ☐ Initial dose: 400mg subcutaneously at weeks 0, 2, and 4 weeks
☐ Maintenance dose: ☐ 200mg subcutaneously every 2 weeks **OR** ☐ 400mg subcutaneously every 4 weeks
- ☐ **Krystexxa:** ☐ 8mg IV every 2 weeks
- ☐ **Immunoglobulin:** ☐ IV ☐ Subcutaneous _____ ☐ gm/kg ☐ mg/kg x _____ day(s) OR divided over _____ days
 Frequency: Every _____ weeks or _____
- ☐ **Orencia:** Dose: _____ mg IV
 Frequency: ☐ Every 4 weeks **OR** ☐ 0,2,4 weeks, and every 4 weeks thereafter
- ☐ **Simponi Aria:** ☐ Initial Dose: 2mg/kg at weeks 0,4, and then every 8 weeks
☐ Maintenance Dose: 2mg/kg every 8 weeks
- ☐ **Stelara:** ☐ Initial Dose: ☐ 45mg subcutaneously initially, 4 weeks later, followed by 45mg every 12 weeks
☐ 90mg subcutaneously initially, 4 weeks later, followed by 90mg every 12 weeks
☐ Maintenance Dose: ☐ 45mg ☐ 90mg subcutaneously every 12 weeks
- ☐ **Infliximab:** Dose: _____ mg/kg Frequency: ☐ Every _____ weeks ☐ 0, 2, 6, then every 8 weeks
- ☐ **Rituximab:** Dose: ☐ 1000mg ☐ 375mg/m²
 Frequency: ☐ One time dose ☐ Weekly x4 weeks ☐ Day 0, repeat dose in 2 weeks
- ☐ **Saphnelo:** ☐ 300mg IV every 4 weeks

PROVIDER INFORMATION:

By signing this form, you authorize US Infusions and its staff to handle prior authorizations, coordinate with insurance providers, and determine the patient's preferred site of care.

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

****PLEASE COMPLETE BOTH SIDES OF THIS FORM****

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THERAPIES TRIED AND FAILED, INTOLERANCES, OR CONTRAINDICATIONS TO CONVENTIONAL THERAPY:

REQUIRED PRE-SCREENING:

☐ TB screening test completed within 12 months w/attached ☐ Positive ☐ Negative results

Required for: Actemra, Cimzia, Infliximab, Simponi Aria, Stelara, and Orencia

☐ Hepatitis B screening (surface antigen) w/attached ☐ Positive ☐ Negative results

Required for: Actemra, Cimzia, Infliximab, Rituximab, and Simponi Aria

☐ Hepatitis B core antibody total (not IgM) w/attached ☐ Positive ☐ Negative results

Required for: Rituximab

☐ Serum immunoglobulins w/attached results *Required for: Rituximab*

☐ Baseline creatinine w/attached results *Required for: IVIG*

**if TB or HepB results are positive attach documentation of treatment or medical clearance, and a negative CXR (TB+)*

REQUIRED ASSOCIATED DOCUMENTATION:

☐ Patient demographics ☐ Front/back of all insurance cards ☐ Current medication list ☐ Labs and/or test results

☐ Include clinical notes supporting the above diagnoses.

☐ Include clinical notes supporting contraindication/intolerance, or failed trial of conventional therapy or biologic.

☐ *If applicable* - Last know biological therapy: _____ and last date received: _____

☐ If switching to biologic therapy - please perform a wash-out period of _____ weeks prior to starting ordered biologic.