US infusions

RHEUMATOLOGY ORDER SET

RHEUMATOLOGY ORDERS:

Patient Name: _____ DOB: _____ Phone: _____
☐ New to therapy ☐ Continuing therapy: next treatment date: _____.

MEDICAL INFORMATION:

☐ 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: _____

THERAPY ORDERS:

☐ **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

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

_____

_____

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

11500 TX-121 STE 910 FRISCO, TX 75035 P:469-200-2605 F:469-200-2606

US infusions

RHEUMATOLOGY ORDER SET

RHEUMATOLOGY ORDERS:

Patient Name: _____ DOB: _____ Phone: _____

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.

REFERRING PROVIDER INFORMATION:

Provider name: _____ Signature:_____ Date:_____

NPI: _____ Phone: _____ Fax: _____

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

FAX COMPLETED FORM TO US INFUSIONS AT 469-200-2606

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