

Patient information

Patient name _____

DOB _____

Mobile number _____

Weight _____ kgs lbs

Diagnosis Psoriatic arthritis
 Ankylosing spondylitis
 Non-radiographic axial spondyloarthritis
 Other _____

Allergies NKDA _____

Medication instructions

Pre-medications N/A
 Provider prescribed: _____

Medication order Dose Frequency
 With loading dose: 6 mg/kg given at week 0, followed by 1.75 mg/kg every 4 weeks thereafter Every 4 weeks
 Without loading dose: 1.75 mg/kg * loading dose optional * max. maintenance dose 300 mg per infusion other Other _____
 Other _____

Medication route IV
 Other _____

Lab order (Include frequency) Please list any labs to be drawn by the infusion clinic:
 N/A

Prerequisites Please include the following with your fax submission: Labs and tests supporting diagnosis | Office / progress notes | Demographics | Negative TB test result

Please send to Columbia, MD Silver Spring, MD Bowie, MD Frederick, MD

Referring provider information

Referring provider name _____ NPI _____

Practice name _____

Point of contact Name _____ Email _____ Phone _____

Provider signature _____ Date _____