

PATIENT

PATIENT NAME		DATE OF BIRTH	PHONE
ADDRESS		CITY / STATE / ZIP	EMAIL
WEIGHT _____ ☐ kg ☐ lb	HEIGHT _____ ☐ cm ☐ in	ALLERGIES	PATIENT STATUS ☐ New ☐ Continuing

DIAGNOSIS ICD-10 required — check one or write it in

- | | | |
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| ☐ M05.79 Seropositive RA, multiple sites | ☐ L40.50 Psoriatic arthropathy, unspec. | ☐ M31.6 Giant cell arteritis |
| ☐ M06.09 Seronegative RA, multiple sites | ☐ L40.52 Psoriatic arthritis mutilans | ☐ M31.31 GPA with lung involvement |
| ☐ M06.9 Rheumatoid arthritis, unspecified | ☐ M45.9 Ankylosing spondylitis | ☐ M31.7 Microscopic polyangiitis |
| ☐ M08.00 Juvenile idiopathic arthritis | ☐ M32.10 SLE with organ involvement | ☐ M1A.9XX0 Chronic gout, refractory |

OTHER ICD-10	DIAGNOSIS DESCRIPTION

PRESCRIBER & INSURANCE

PRESCRIBER NAME	NPI #	PHONE	FAX
OFFICE CONTACT	EMAIL	NEXT TREATMENT DATE	TAX ID
PRIMARY INSURANCE	POLICY #	GROUP #	
SECONDARY INSURANCE	POLICY #	GROUP #	

PRIOR THERAPY

- ☐ Documented contraindication, intolerance or failed trial of a conventional therapy such as steroids? ☐ Yes ☐ No
Which drugs: _____
- ☐ Contraindication, intolerance or failed trial of another biologic? ☐ Yes ☐ No
Which drugs: _____
- ☐ Last biologic: _____ Last dose received: _____ Wash-out before starting: _____ weeks
- ☐ CRS only — prior CAR-T therapy (Kymriah, Yescarta) or Blincyto? ☐ Yes ☐ No Which: _____
- ☐ Other medical necessity: _____

REQUIRED PRE-SCREENING attach all results

- ☐ TB screening within 12 months. ☐ Positive ☐ Negative Actemra · Cimzia · infliximab · ustekinumab · Simponi Aria · Orencia
- ☐ Hepatitis B surface antigen. ☐ Positive ☐ Negative Actemra · Cimzia · infliximab · rituximab · Simponi Aria
- ☐ Hepatitis B core antibody total, not IgM. ☐ Positive ☐ Negative rituximab
- ☐ **G6PD level.** ☐ Normal ☐ Deficient required before Krystexxa — see the box below
- ☐ Serum immunoglobulins. recommended for rituximab
- ☐ Baseline creatinine. required for immunoglobulin
- ☐ CBC with differential and liver panel. required for Actemra — see the box below
- ☐ Serum uric acid. required for Krystexxa, before every infusion

If TB or hepatitis B is positive, attach documentation of treatment or medical clearance, and a negative chest X-ray for TB.

BEFORE THE FIRST DOSE — DRUG-SPECIFIC

Krystexxa	G6PD deficiency is a contraindication. Screen before the first dose. Risk is higher in patients of African, Mediterranean, Middle Eastern and Southern Asian ancestry. Hemolysis and methemoglobinemia have occurred. Stop all oral urate-lowering therapy before starting. Check serum uric acid before each infusion and stop Krystexxa if it rises above 6 mg/dL.
Actemra	Do not start if ANC is below 2,000/mm ³ , platelets are below 100,000/mm ³ , or ALT/AST is above 1.5 × ULN.
Rituximab	Screen every patient for hepatitis B — reactivation can be fatal. For GPA and MPA, give PCP prophylaxis during treatment and for at least 6 months after the last dose.

PATIENT NAME	DATE OF BIRTH

SELECT ONE MEDICATION infusion time shown under each drug — for chair scheduling

DRUG	DOSE & SCHEDULE	REFILL
Actemra <i>tocilizumab</i> IV • 60 min	☐ RA: 4 mg/kg q4w , may increase to 8 mg/kg q4w on response — max 800 mg ☐ GCA: 6 mg/kg q4w with a tapering glucocorticoid course — max 600 mg ☐ pJIA, age 2+: 10 mg/kg if <30 kg, 8 mg/kg if ≥30 kg — every 4 weeks ☐ sJIA, age 2+: 12 mg/kg if <30 kg, 8 mg/kg if ≥30 kg — every 2 weeks ☐ Other: _____ mg IV every _____ weeks	☐ × 1 year ☐ _____
Cimzia <i>certolizumab pegol</i> SubQ	☐ Induction: 400 mg SubQ at weeks 0, 2 and 4 Maintenance: ☐ 200 mg SubQ every 2 weeks ☐ 400 mg SubQ every 4 weeks	☐ × 1 year ☐ _____
Immunoglobulin <i>IVIg / SCIg</i> IV or SubQ	Route: ☐ IV ☐ SubQ Dose: _____ g/kg ☐ mg/kg Frequency: every _____ weeks ☐ Divide over _____ days ☐ LIVbetter to select product per coverage Brand: _____	☐ × 1 year ☐ _____
Infliximab <i>and biosimilars</i> IV • ≥ 2 hr	Dose: _____ mg/kg Frequency: ☐ weeks 0, 2, 6 then every 8 weeks ☐ every _____ weeks ☐ May substitute biosimilar per coverage ☐ Do not substitute — brand: _____	☐ × 1 year ☐ _____
Krystexxa <i>pegloticase</i> IV • ≥ 120 min	☐ 8 mg IV every 2 weeks ☐ Methotrexate 15 mg PO weekly + folic acid — start at least 4 weeks before the first dose and continue throughout ☐ Methotrexate is contraindicated or not appropriate — give Krystexxa alone ☐ Flare prophylaxis (NSAID or colchicine) started 1 week before, continued 6 months G6PD screening is required before the first dose — contraindicated if deficient. Stop oral urate-lowering drugs. Check uric acid before every infusion; stop if >6 mg/dL.	☐ × 1 year ☐ _____
Orencia <i>abatacept</i> IV • 30 min	Adult, by weight: ☐ under 60 kg: 500 mg ☐ 60–100 kg: 750 mg ☐ over 100 kg: 1,000 mg ☐ pJIA age 6+, under 75 kg: 10 mg/kg ☐ pJIA 75 kg or more: use the adult weight bands, max 1,000 mg Schedule: weeks 0, 2 and 4, then every 4 weeks	☐ × 1 year ☐ _____
Rituximab <i>and biosimilars</i> IV • rate-escalated	☐ RA: 1,000 mg IV × 2 doses, 2 weeks apart, with methotrexate ☐ GPA / MPA: 375 mg/m ² IV weekly × 4 doses ☐ Premedicate with methylprednisolone 100 mg IV 30 minutes before each dose — per label ☐ Repeat course — no sooner than every 16 weeks; usually every 24 weeks ☐ May substitute biosimilar ☐ Do not substitute — brand: _____	☐ × 1 year ☐ _____
Saphnelo <i>anifrolumab</i> IV • 30 min	☐ 300 mg IV every 4 weeks	☐ × 1 year ☐ _____
Simponi Aria <i>golimumab</i> IV • 30 min	☐ 2 mg/kg IV at weeks 0 and 4, then every 8 weeks	☐ × 1 year ☐ _____
Ustekinumab <i>and biosimilars</i> SubQ	☐ 45 mg SubQ at week 0, again at week 4, then every 12 weeks ☐ 90 mg SubQ at week 0, again at week 4, then every 12 weeks — for weight over 100 kg with plaque psoriasis ☐ May substitute biosimilar ☐ Do not substitute — brand: _____	☐ × 1 year ☐ _____
Other	Drug: _____ Dose: _____ Route: _____ Frequency: _____	☐ × 1 year ☐ _____

PRE-MEDICATIONS & LABS

Pre-meds	☐ Acetaminophen ☐ 500 ☐ 1,000 mg PO ☐ Diphenhydramine 25 mg ☐ PO ☐ IV ☐ Loratadine 10 mg PO ☐ Cetirizine 10 mg PO ☐ Methylprednisolone _____ mg IV ☐ Solu-Cortef _____ mg IV ☐ Other: _____
Labs	Orders: _____ Frequency: _____ ☐ Yearly TB (QFT) ☐ Baseline hepatitis B core antibody total Drawn by: ☐ LIVbetter ☐ Referring provider

PRESCRIBER SIGNATURE required — we cannot schedule without it

By signing, you authorize LIVbetter Infusions to act as your prior authorization and specialty pharmacy designated agent with insurance companies and to select the site of care. Where your state requires it, check "Dispense as written" to prevent generic substitution.

PRESCRIBER SIGNATURE	DATE	DISPENSE AS WRITTEN
X		☐ Yes

SEND WITH EVERY REFERRAL

- ☐ Signed and completed order — pages 1 and 2
- ☐ Patient demographic and insurance information
- ☐ Current medication list
- ☐ Clinical notes covering tried and failed therapies, intolerance, or contraindication to conventional therapy
- ☐ Labs and test results supporting the diagnosis