RHEUMATOLOGY ORDER FORM

P: 240.200.4464 F: 240.892.3005

PATIENT INFORMATION: Fax completed form, insurance information, and clinical documentation to 240.892.3005

Patient Name: _____ DOB: _____ Phone: _____

MEDICAL INFORMATION

Patient Weight: _____ lbs./kg. (required) Patient Height: _____ Allergies: _____

Diagnosis: _____

- ☐ Rheumatoid Arthritis, Unspecified
- ☐ Unspecified Iridocyclitis
- ☐ Arthropathic Psoriasis, Unspecified
- ☐ Rheumatoid Arthritis w/ Rheumatoid Factor, Unspecified
- ☐ Rheumatoid Arthritis w/out Rheumatoid Factor, Unspecified

ICD-10 Code: _____

- ☐ Ankylosing Spondylitis, Unspecified
- ☐ Gout
- ☐ Wegener's granulomatosis
- ☐ Systemic Lupus Erythematosus
- ☐ Other: _____

THERAPY ORDER

Drug	Dosing	Refill
Actemra	☐ 4 mg/kg IV every 4 weeks for _____ doses, then 8mg/kg IV every 4 weeks ☐ 4mg/kg IV every 4 weeks ☐ 8mg/kg IV every 4 weeks ☐ Other dose: _____ mg IV every _____ weeks	
Cimzia	☐ **Initial Dose:** 400mg SubQ at weeks 0, 2, and 4 ☐ **Maintenance Dose:** ☐ 200mg SubQ every 2 weeks **OR** ☐ 400mg SubQ every 4 weeks	
Krystexxa	☐ 8mg IV every 2 weeks	
Immunoglobulin (Ig)	☐ **IV** ☐ **SubQ** Brand: _____ Active Infusions to choose if not indicated ☐ _____ gm/kg x _____ day(s) **OR** divided over _____ day(s) ☐ _____ mg/kg x _____ day(s) **OR** divided over _____ day(s) **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 IV at weeks 0, 4, and then every 8 weeks ☐ **Maintenance Dose:** 2mg/kg IV every 8 weeks	
Stelara	**Initial Dose:** ☐ 45mg SubQ initially, at 4 weeks, then 45mg SubQ every 12 weeks ☐ 90mg SubQ initially, at 4 weeks, then 90mg SubQ every 12 weeks **Maintenance Dose:** ☐ 45mg SubQ every 12 weeks **OR** ☐ 90mg SubQ every 12 weeks	
Infliximab	☐ May substitute biosimilar per insurance requirement ☐ Do not substitute. Brand: _____ **Dose:** _____ mg/kg IV **Frequency:** ☐ Every _____ weeks **OR** ☐ 0, 2, 6, then every 8 weeks	
Rituximab	☐ May substitute biosimilar per insurance requirement ☐ Do not substitute. Brand: _____ **Dose:** ☐ 1000mg **OR** ☐ 375mg/m2 **OR** ☐ Other: _____ **Frequency:** ☐ One-time dose **OR** ☐ Weekly x 4 weeks **OR** ☐ Day 0, repeat dose in 2 weeks	
Saphnelo	☐ 300mg IV every 4 weeks	

Premedication orders: Tylenol ☐ 1000mg OR ☐ 500 mg PO
Please choose one antihistamine: ☐ Diphenhydramine 25mg PO ☐ Loratadine 10mg PO ☐ Cetirizine 10mg PO ☐ Other: _____
Additional premedications: ☐ Solu-Medrol _____ mg IVP ☐ Solu-Cortef _____ mg IVP ☐ Other: _____

Please provide patient's demographic information, insurance information, medication list, and clinical notes. Active Infusions will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and assist them in enrolling in any available co-pay assistance programs as needed/applicable. Thank you for the referral.

PROVIDER INFORMATION

Provider Name: _____ Signature: _____ Date: _____

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