



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: _____ <input type="checkbox"/> Rheumatoid Arthritis, Unspecified <input type="checkbox"/> Unspecified Iridocyclitis <input type="checkbox"/> Arthropathic Psoriasis, Unspecified <input type="checkbox"/> Rheumatoid Arthritis w/ Rheumatoid Factor, Unspecified <input type="checkbox"/> Rheumatoid Arthritis w/out Rheumatoid Factor, Unspecified	ICD-10 Code: _____ <input type="checkbox"/> Ankylosing Spondylitis, Unspecified <input type="checkbox"/> Gout <input type="checkbox"/> Wegener's Granulomatosis <input type="checkbox"/> Systemic Lupus Erythematosus <input type="checkbox"/> Other: _____
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Drug	Dosing	Refill
Actemra	<input type="checkbox"/> 4 mg/kg IV every 4 weeks for ____ doses, then 8mg/kg IV every 4 weeks <input type="checkbox"/> 4mg/kg IV every 4 weeks <input type="checkbox"/> 8mg/kg IV every 4 weeks <input type="checkbox"/> Other dose: _____ mg IV every _____ weeks	<input type="checkbox"/> _____ <input type="checkbox"/> x 1 year
Adakveo	<input type="checkbox"/> 5 mg/kg IV at Week 0, Week 2, then every 4 weeks	<input type="checkbox"/> _____ <input type="checkbox"/> x 1 year
Krystexxa	<input type="checkbox"/> 8mg IV every 2 weeks Pre-medication protocol: Diphenhydramine 50mg PO, Methylprednisolone 125mg IV, Acetaminophen 1000mg PO	<input type="checkbox"/> _____ <input type="checkbox"/> x 1 year
Immunoglobulin (Ig)	<input type="checkbox"/> IV <input type="checkbox"/> SubQ Brand: _____ <i>Active Infusions to choose if not indicated</i> <input type="checkbox"/> _____ gm/kg x _____ day(s) OR divided over _____ day(s) <input type="checkbox"/> _____ mg/kg x _____ day(s) OR divided over _____ day(s) Frequency: Every _____ weeks OR _____	<input type="checkbox"/> _____ <input type="checkbox"/> x 1 year
Orencia	Dose: _____ mg IV Frequency: <input type="checkbox"/> Every 4 weeks <input type="checkbox"/> 0, 2, 4 weeks and every 4 weeks thereafter	<input type="checkbox"/> _____ <input type="checkbox"/> x 1 year
Simponi Aria	<input type="checkbox"/> Initial Dose: 2mg/kg IV at weeks 0, 4, and then every 8 weeks <input type="checkbox"/> Maintenance Dose: 2mg/kg IV every 8 weeks	<input type="checkbox"/> _____ <input type="checkbox"/> x 1 year
Stelara	Initial Dose: <input type="checkbox"/> 45mg SubQ initially, at 4 weeks, then 45mg SubQ every 12 weeks <input type="checkbox"/> 90mg SubQ initially, at 4 weeks, then 90mg SubQ every 12 weeks Maintenance Dose: <input type="checkbox"/> 45mg SubQ every 12 weeks OR <input type="checkbox"/> 90mg SubQ every 12 weeks	<input type="checkbox"/> _____ <input type="checkbox"/> x 1 year
Infliximab	<input type="checkbox"/> May substitute biosimilar per insurance requirement <input type="checkbox"/> Do not substitute. Brand: _____ Dose: _____ mg/kg IV Frequency: <input type="checkbox"/> Every _____ weeks OR <input type="checkbox"/> 0, 2, 6, then every 8 weeks	<input type="checkbox"/> _____ <input type="checkbox"/> x 1 year
Rituximab	<input type="checkbox"/> May substitute biosimilar per insurance requirement <input type="checkbox"/> Do not substitute. Brand: _____ Dose: <input type="checkbox"/> 1000mg OR <input type="checkbox"/> 375mg/m ² OR <input type="checkbox"/> Other: _____ Frequency: <input type="checkbox"/> One-time dose OR <input type="checkbox"/> Weekly x 4 weeks OR <input type="checkbox"/> Day 0, repeat dose in 2 weeks Pre-medication protocol: Benadryl 50mg IV/PO & Solu-Medrol 100mg IV	<input type="checkbox"/> _____ <input type="checkbox"/> x 1 year
Saphnelo	<input type="checkbox"/> 300mg IV every 4 weeks	<input type="checkbox"/> _____ <input type="checkbox"/> x 1 year

Premedication orders: Tylenol 1000mg 650 mg PO OR 500 mg PO
 Please choose one antihistamine Diphenhydramine 25mg PO/IV Diphenhydramine 50mg PO/IV Loratadine 10mg PO
 Cetirizine 10mg PO Other: _____
 Additional premedications: Solu-Medrol _____ mg IVP Solu-Cortef _____ mg IVP Other: _____

PROVIDER INFORMATION

Please provide the patient's demographic information, insurance information, medication list, and clinical notes. Active Infusions will complete insurance verification and submit required documentation for approval. Thank you for the referral.

Provider Name: _____ Signature: _____ Date: _____

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