Care Fusion INFUSION CENTERS

AIC Rheumatology #2

Fax: 855-733-9898
Phone: 877-460-3905

Patient Information

Patient Name: _____ DOB: _____ Height: _____ Weight: _____ Patient Contact #: _____

Medical Assessment

1. **Diagnosis:** ☐ M06.9 Rheumatoid Arthritis ☐ L40.50 Psoriatic Arthritis ☐ Ankylosing Spondylitis ☐ Other: _____
   ☐ M32.10 Systemic lupus erythematosus ☐ M1A.__0 Chronic gout ☐ M10.__ Idiopathic gout
2. **Drug Allergies:** _____
3. **Failed Medications:** ☐ Methotrexate Therapy Length: _____ Discontinuation Reason: _____
   ☐ _____ Therapy Length: _____ Discontinuation Reason: _____

****Please include a demographics page, front and back of an insurance card-medical / RX insurance, any clinical notes with supporting diagnosis, lab-work, tests, and any other supporting documentation including past tried and / or failed therapies associated with diagnosis****

Labwork: _____ To be Drawn by: ☐ Infusion Clinic ☐ Referring Provider

Pre-Medication Orders

- ❑ APAP ☐ 325mg ☐ 500mg ☐ 650mg - PO 30 minutes before infusion.
- ❑ Diphenhydramine ☐ 25mg ☐ 50mg – PO 30 minutes before infusion OR 25mg IVP ☐ 50mg IVP
- ❑ Alternate Oral Antihistamines: ☐ Cetirizine 10mg ☐ Loratadine 10mg ☐ Fexofenadine 60mg or ☐180mg
- ❑ Methylprednisolone ☐ 40mg IVP ☐ 125mg IVP or other _____ mg IVP
- ❑ Famotidine ☐ 20mg PO ☐ 40mg PO ☐ 20mg IVP ☐ 40mg IVP
- ❑ Ondansetron ☐ 4 mg IVP ☐ 4 mg PO

Medication

Infliximab (Remicade & Biosimilars)

❑ ***Preferred*** **- Infusion Clinic Preference (Remicade / Avsola / Inflectra / Renflexis) based on payer directives / availability**
❑ **Specific Product: _____**
Dosage: 3 mg /kg OR _____mg or _____mg / kg
Frequency:
- ❑ Induction: at week 0, 2, and 6 weeks
- ❑ Maintenance: at week 14 and every 8 weeks
- ❑ Other orders: _____
- ❑ **Maintenance Refills**: ___

Orencia (abatacept)

Dosage: ☐ 500mg 750mg ☐ 1000mg
Frequency:
- ❑ Induction: at week 0, 2 and, 4
- ❑ Maintenance: at week 8 and every 4 weeks thereafter
- ❑ **Maintenance Refills**: ___

Rituximab (Rituxan & Biosimilars)

❑ ***Preferred*** **- Infusion Clinic Preference (Rituxan / Ruxience / Truxima) based on payer directives / availability**
❑ **Specific Product: _____**
Dosage: 1000mg IV
Frequency:
- ❑ Infuse at week 0 and 2, once every 4 months (16 weeks)
- ❑ Infuse at week 0 and 2, once every 6 months (24 weeks)
- ❑ Other orders: _____
- ❑ **Maintenance Refills**: ___

***** Pre-medications of acetaminophen PO, diphenhydramine IVP, and methylprednisolone is recommended prior to infusion*****

Physician Prescription Orders

Address: _____ Phone: _____
Fax: _____ Clinic Contact: _____Physician Name: _____
NPI #_____Physician Signature: _____Date: _____