RELIANT SPECIALTY INFUSION

AIC Rheumatology #1 Fax: 833-808-0833

Patient Information

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

Medical Assessment

Please Attach a Demographics Page & Copy of Insurance Card with this Prescription if Available:

1. **Diagnosis:** □ M06.9 Rheumatoid Arthritis □ L40.50 Psoriatic Arthritis □ M45.__ Ankylosing Spondylitis □ Other: _____
   □ M45.A0 Non-radiographic axial spondylarthritis of unspecified sites in the spine
   □ 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: _____
4. **Negative TB Skin Test (PPD Test):** □ Yes □ No When: _____ (Please Attach)

****Please include a demographics page, front and back of an insurance card, 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

Actemra (tocilizumab)

Dosage / Frequency:

- ❑ Induction: 4 mg / kg at week 0
- ❑ Maintenance: □ 4 mg / kg or □ 8mg / kg at week 4 and every 4 weeks thereafter
- ❑ **Maintenance Refills**: ___

Benlysta (belimumab)

Dosage / Frequency:

- ❑ Induction: 10mg/kg at 0, 2, and 4 weeks
- ❑ Maintenance: 10 mg/kg at week 8 and every 4 weeks thereafter
- ❑ **Maintenance Refills**: ___

Cosentyx (secukinumab)

- ❑ With Induction: 6mg / kg IV (_____mg) at week 0, followed by 1.75mg / kg (_____mg) every 4 weeks thereafter (max maintenance dose of 300mg per infusion)
- ❑ Without Induction: 1.75mg / kg IV (_____mg) every 4 weeks thereafter (max maintenance dose of 300mg per infusion)
- ❑ **Maintenance Refills**: ___

Krystexxa (pegloticase)

Dosage:

- ❑ 8 mg every 2 weeks
- ❑ **Maintenance Refills**: ___

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

Physician Prescription Orders

Address: _____ Phone: _____

Fax: _____ Clinic Contact: _____ Physician Name: _____

NPI # _____ ***Physician Signature:*** _____ ***Date:*** _____