RELIANT SPECIALTY INFUSION

AIC Rheumatology #3 **Fax: 833-808-0833**

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: _____
4. **Negative TB Skin Test (PPD Test):** □ Yes □ No When: _____ (Please Attach)

****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 by 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

Saphnelo (anifrolumab-fnia)

Dosage / Frequency:

- ❑ Saphnelo 300mg every 4 weeks
- ❑ **Maintenance Refills**: ___

Stelara (ustekinumab) – *Induction / Maintenance dosage administered SQ in AIC / HCP office only*

Dosage / Frequency:

Induction:

- ❑ 45mg SQ at week 0 and 4
- ❑ 90mg SQ at week 0 and 4

Maintenance:

- ❑ 45mg SQ at week 16 and every 12 weeks thereafter
- ❑ 90mg SQ at week 16 and every 12 weeks thereafter
- ❑ **Maintenance Refills**: ___

Simponi Aria (golimumab)

Dosage: 2 mg / kg (_____mg)

Frequency:

- ❑ Induction Dose: at week 0 and 4
- ❑ Maintenance Dose: at week 12 and every 8 weeks thereafter
- ❑ Other: _____
- ❑ **Maintenance Refills**: ___

Physician Prescription Orders

Address: _____ Phone: _____

Fax: _____ Clinic Contact: _____Physician Name: _____

NPI #_____Physician Signature: _____***Date:*** _____