RHEUMATOLOGY ENROLLMENT FORM - "INFUSION"

PATIENT INFORMATION

Last Name _____ First Name _____

Social Security # _____ Date of Birth _____

Address: _____

Sex ⊔ M ⊔ F Wgt:_____ Ht:_____ Phone:_____

Allergies:_____ Cell:_____

TREATMENT ARRANGEMENTS

Start Date: _____

Ship Meds: □ Home □ Doctor's Office

Teaching by: □ Doctor's Office

□ Other: _____

Diagnosis: □ Rheumatoid Arthritis □ Ankylosing Spondylitis □ Osteoporosis □ Psoriatic Arthritis □ Lupus □ Gout □ Spondyloarthropathy

Date of Diagnosis: _____

INSURANCE INFORMATION

Insurance: □ Medicare □ Medicaid □ Commercial: _____

ID _____ BIN_____ PCN _____ GROUP_____

Premeds: □Tylenol 500mg 2 PO □ Loratidine 10mg PO □ Zyrtec 10mg PO □ Benadryl _____mg IV/PO (circle one)
□ SoluCortef _____mg IV □ Ondansetron___mg IV □ Promethazine__ mg IV □ Other

√ Standing Order: Anaphylaxis Protocol √ **Skilled Nurse to start PIV, infuse per protocol, DC PIV each visit**

□ Lab Draw As Follows:_____

□ Quantiferon Gold Lab Draw Q _____ □ Patient to FU w/MD Q_____

Prior Treatment: □ **Humira** □ **Enbrel** □ **Stelara** □ **Others:**_____ **TB Test** □ **Positive** □ **Negative**

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSAGE FORM	DIRECTIONS	QUANTITY	REFILLS
□ **Actemra**	□ 80mg/4ml □ 200mg/10ml □ 400mg/20ml □_____mg/kg	IV	□ Induction Dose: 4 mg/kg every 4 weeks. □ Maint. Dose: (based on clinical response): 8 mg/kg every 4 weeks. □ Other: _____		
□ **Benlysta**	□ 10mg/kg		□ Induction Dose: Administer 10 mg/kg on week 0, week 2 week 4. □ Maint. Dose: 10 mg/kg once every 4 weeks after Induction dose. □ Other:		
□ **Boniva**	□ 3mg/3ml Injection		□ Inject 3mg/ml Once every 3 months. □ Other:		
□ **Krystexxa**	□ 8mg/ml		□ Inject 8mg/ml Intravenous once every 2 weeks. □ Other:		
□ **Orencia**	□ 250mg Vial □ _____ mg/kg		□ Infuse _____mg in 100ml of 0.9% NaCl at weeks 0, 2, and 4, then every 4 weeks thereafter. □ Other:		
□ **Remicade**	□ 100mg Vial □ 300mg/kg		□ Induction Dose: IV in 250ml of 0.9% NaCl at weeks 0, 2, and 6 weeks. □ Maint. Dose: IV in 250ml of 0.9% NaCl every 8 weeks. □ Maint. Dose: IV in 250ml of 0.9% NaCl every 6 weeks. □ Other:		
□ **Rituxan**	□ 100mg/10ml vial □ 500mg/50ml vial		□ Infuse two doses of 100mg in 1 liter of 0.9% NaCl separated by 2 weeks. □ Other:		
□ **Reclast**	□ 5mg/100ml		□ 5mg/100ml Once every year. □ Other:		
□ **Simponi Aria**	□ _____ mg/kg		□ Inject 2 mg/kg intravenous (IV) infusion over 30 minutes at Weeks 0 and 4, then every 8 weeks thereafter □ Other:		

Physician Signature: _____ □ **DAW (Dispense as Written) Date:** _____

Physician Name: _____ **Phone:** _____ **Fax:** _____ **Office Contact:** _____

Physician Address: _____ **NPI:** _____ **DEA:**_____

X By Signing this prescription & using Southside's services, you are authorizing Southside to contact insurance companies for prior authorizations on behalf of your practice.

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