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)
□ Solu-Medrol _____mg IV □ Solu-cortef _____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_____

PRESCRIPTION INFORMATION

MEDICATION	DIRECTIONS	DURATION
□ **Actemra**	□ 4 mg/kg IV every 4 weeks. □ 8 mg/kg IV every 4 weeks. (Max 800mg) □ Other: _____	□ 1 Year Or □
□ **Benlysta**	□ Induction Dose: 10 mg/kg IV on week 0, week 2 week 4. □ Maint. Dose: 10 mg/kg IV once every 4 weeks after Induction dose. □ Other: _____	□ 1 Year Or □
□ **Inflectra**	□ Induction Dose: _____mg/kg in 250ml of 0.9% NaCl at week 0,2 and 6. □ Maint. Dose: _____mg/kg in 250ml of 0.9% NaCl every 8 weeks. □ Other: _____	□ 1 Year Or □
□ **Orencia**	□ Infuse _____mg in 100ml of 0.9% NaCl at weeks 0, 2, and 4, then every 4 weeks thereafter. □ Maint Dose: _____ mg every 4 weeks. □ Other: _____	□ 1 Year Or □
□ **Remicade**	□ Induction Dose: _____mg/kg in 250ml of 0.9% NaCl at weeks 0, 2 and 6. □ Maint. Dose: _____mg/kg in 250ml of 0.9% NaCl every 8 weeks. □ Maint. Dose: _____mg/kg in 250ml of 0.9% NaCl every 6 weeks. □ Other: _____	□ 1 Year Or □
□ **Rituxan**	□ Infuse two doses of 1000mg separated by 2 weeks and repeat the cycle every 6 month. □ Other: _____	□ 1 Year Or □
□ **Renflexis**	□ Induction Dose: _____mg/kg in 250ml of 0.9% NaCl at weeks 0, 2 and 6. □ Maint. Dose: _____mg/kg in 250ml of 0.9% NaCl every 8 weeks. □ Maint. Dose: _____mg/kg in 250ml of 0.9% NaCl every 6 weeks. □ Other: _____	□ 1 Year Or □
□ **Reclast**	□ 5mg/100ml Once every year. □ Other: _____	□ 1 Year Or □
□ **Simponi Aria**	□ Inject 2 mg/kg (IV) infusion over 30 minutes at Weeks 0 and 4, then every 8 weeks thereafter. □ 2mg/kg every 8 weeks. □ Other: _____	□ 1 Year Or □

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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