

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 600mg 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
<input type="checkbox"/> Actemra	<input type="checkbox"/> 80mg/4ml <input type="checkbox"/> 200mg/1 0ml <input type="checkbox"/> 400mg/20ml <input type="checkbox"/> ____mg/kg	IV	<input type="checkbox"/> Induction Dose: 4 mg/kg every 4 weeks. <input type="checkbox"/> Main! Dose: (based on clinical response): 8 mg/kg every 4 weeks. <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Benlysta	<input type="checkbox"/> 10mg/kg		<input type="checkbox"/> Induction Dose: Administer 10 mg/kg on week 0, week 2 week 4. <input type="checkbox"/> Main! Dose: 10 mg/kg once every 4 weeks after Induction dose. <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Boniva	<input type="checkbox"/> 3mg/3ml Injection		<input type="checkbox"/> Inject 3mg/ml Once every 3 months. <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Krystexxa	<input type="checkbox"/> D Bmg/ml		<input type="checkbox"/> Inject Bmg/ml Intravenous once every 2 weeks. <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Orencia	<input type="checkbox"/> 250mg Vial <input type="checkbox"/> ____ mg/kg		<input type="checkbox"/> Infuse ____ mg in 100ml of 0.9% NaCl at weeks 0, 2, and 4, then every 4 weeks thereafter. <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Remicade	<input type="checkbox"/> 100mg Vial <input type="checkbox"/> 300mg/kg		<input type="checkbox"/> Induction Dose: IV in 250ml of 0.9% NaCl at weeks 0, 2, and 6 weeks. <input type="checkbox"/> Maint. Dose: IV in 250ml of 0.9% NaCl every 8 weeks. <input type="checkbox"/> Maint. Dose: IV in 250ml of 0.9% NaCl every 6 weeks. <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Rituxan	<input type="checkbox"/> 100mg/10ml vial <input type="checkbox"/> 500mg/50ml vial		<input type="checkbox"/> Infuse two doses of 100mg in 1 liter of 0.9% NaCl separated by two weeks. <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Reclast	<input type="checkbox"/> 5mg/100ml		<input type="checkbox"/> 5mg/100ml Once every year. <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Simponi Aria	<input type="checkbox"/> ____ mg/kg	<input type="checkbox"/> Inject 2mg/kg intravenous (IV) infusion over 30 minutes at week 0 and week 4, then every 8 weeks thereafter. <input type="checkbox"/> Other: _____			

Physician Signature: _____ ¶ DAW (Dispense as Written) Date: _____

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

Physician Address: _____ NPI: _____ DEA: _____

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