City Infusions
WWW.CITYINFUSIONS.COM
Phone: 703-375-9577 Fax: 703-839-9750

RHEUMATOLOGY INFUSION ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____

MEDICAL INFORMATION

Patient Weight: _____ lbs./kg. (required) Patient Height: _____ Allergies: _____

Diagnosis: _____
□ Rheumatoid Arthritis, Unspecified
□ Unspecified Iridocyclitis
□ Arthropathic Psoriasis, Unspecified
□ Rheumatoid Arthritis w/ Rheumatoid Factor, Unspecified
□ Rheumatoid Arthritis w/out Rheumatoid Factor, Unspecified

ICD-10 Code: _____
□ Ankylosing Spondylitis, Unspecified
□ Gout
□ Wegener's Granulomatosis
□ Systemic Lupus Erythematosus
□ Other: _____

Drug	Dosing	Refill
Actemra	□ 4 mg/kg IV every 4 weeks for ____ doses, then 8mg/kg IV every 4 weeks □ 4mg/kg IV every 4 weeks □ 8mg/kg IV every 4 weeks □ Other dose: _____ mg IV every _____ weeks	□ _____ □ x 1 year
Adakveo	□ 5 mg/kg IV at Week 0, Week 2, then every 4 weeks	□ _____ □ x 1 year
Krystexxa	□ 8mg IV every 2 weeks **Pre-medication protocol:** Diphenhydramine 50mg PO, Methylprednisolone 125mg IV, Acetaminophen 1000mg PO	□ _____ □ x 1 year
Immunoglobulin (Ig)	□ IV □ SubQ Brand: _____ (City Infusions will choose if not indicated) □ _____ gm/kg x _____ day(s) OR divided over _____ day(s) □ _____ mg/kg x _____ day(s) OR divided over _____ day(s) **Frequency: Every** _____ weeks OR _____	□ _____ □ x 1 year
Orencia	**Dose:** _____ mg IV Frequency: □ Every 4 weeks □ 0, 2, 4 weeks and every 4 weeks thereafter	□ _____ □ x 1 year
Simponi Aria	□ Initial Dose: 2mg/kg IV at weeks 0, 4, and then every 8 weeks □ Maintenance Dose: 2mg/kg IV every 8 weeks	□ _____ □ x 1 year
Stelara	**Initial Dose:** □ 45mg SubQ initially, at 4 weeks, then 45mg SubQ every 12 weeks □ 90mg SubQ initially, at 4 weeks, then 90mg SubQ every 12 weeks **Maintenance Dose:** □ 45mg SubQ every 12 weeks OR □ 90mg SubQ every 12 weeks	□ _____ □ x 1 year
Infliximab	□ May substitute biosimilar per insurance requirement □ Do not substitute. Brand: _____ **Dose:** _____ mg/kg IV Frequency: □ Every _____ weeks OR □ 0, 2, 6, then every 8 weeks	□ _____ □ x 1 year
Rituximab	□ May substitute biosimilar per insurance requirement □ Do not substitute. Brand: _____ **Dose:** □ 1000mg OR □ 375mg/m² OR □ Other: _____ **Frequency:** □ One-time dose OR □ Weekly x 4 weeks OR □ Day 0, repeat dose in 2 weeks **Pre-medication protocol:** Benadryl 50mg IV/PO & Solu-Medrol 100mg IV	□ _____ □ x 1 year
Saphnelo	□ 300mg IV every 4 weeks	□ _____ □ x 1 year

Premedication orders: Tylenol □ 1000mg □ 650 mg PO OR □ 500 mg PO
Please choose one antihistamine□ Diphenhydramine 25mg PO/IV □ Diphenhydramine 50mg PO/IV □ Loratadine 10mg PO
□ Cetirizine 10mg PO □ Other: _____
Additional premedications: □ Solu-Medrol _____ mg IVP □ Solu-Cortef _____ mg IVP □ Other: _____

PROVIDER INFORMATION

Please provide the patient's demographic information, insurance information, medication list, and clinical notes. City Infusions will complete insurance verification and submit required documentation for approval. Thank you for the referral.

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____