

RHEUMATOLOGY ENROLLMENT FORM

Ph: 714.698.4325 | Fax: 714.485.7063 | altheainfusion.com | altheapharmacy.com



* Patient Name: _____ DOB: / / Height: _____ Weight: _____ kg Date: / /
 Allergies: _____ Email: _____
 Address: _____ Ph: _____ Prescriber Signature _____ Sip to: A Patient MD Office
 * Prescriber: _____ Ph: _____ Fax: _____ Altea Location: A

DOCUMENTS TO INCLUDE WITH REFERRAL DIAGNOSIS

- * Patient demographics
 - * Copies of insurance card (front and back)
 - * Pharmacy Card
 - * **Labs:** TB (Quantiferon or PPD), Hepatitis B & C panel, HIV screening (required prior to initiation of biologics)
 - * Specialist consults and recent progress notes
 - Prior medications and therapies (failed or inadequate response)
 - Relevant imaging studies (MRI, CT, X-ray, etc.)
 - Baseline functional assessment with detailed symptom history
- TB/PPD Test: Positive Negative

- M06.9 Rheumatoid Arthritis
- M45.9 Ankylosing Spondylitis
- M32.9 Systemic Lupus Erythematosus
- M08.00 Unspecified Juvenile Rheumatoid Arthritis
- L40.0 Moderate to Severe Plaque Psoriasis
- L40.50 Psoriatic Arthritis
- L40.59 Psoriasis with Arthropathy
- M10.9 Gout, unspecified
- Other _____

IMMUNE GLOBULIN PRESCRIPTION (IVIG): SUBCUTANEOUS IMMUNE GLOBULIN PRESCRIPTION (SCIG):

Loading Dose: _____ grams/kg infused over _____ day(s)
 _____ grams daily for _____ day(s)
Maintenance: _____ grams/kg infused over _____ day(s)
 _____ grams daily for _____ day(s)
 Repeat course every _____ week(s) refill x 1 year

SCIG _____ gras` monthly **OR** _____ gras` every _____ weeks.
 Refill x 1 year. Pharmacy to select number of infusion sites and needle length.

Brand Name: _____ Multiple doses will be administered on consecutive days unless ordered otherwise. **Non-consecutive days OK** OK to round to the nearest vial size. +/- 4 days to allow scheduling flexibility.

PRESCRIPTION DOSAGE AND ADMINISTRATION

Actemra	IV	SC	IV: Induction dose: Infuse 4mg/kg every 4 weeks. Maintenance Dose: Infuse up to 8mg/kg every 4 weeks based on clinical response.	SC: 162 mg SC every week or every other week
Benlysta®	IV	SC	IV: Induction dose: 0mg per kg. `ose` ` _____ mg at 2 week intervals for the first 3 doses then every 4 weeks Maintenance dose: 10mg per kg. Dose = _____ mg every 4 weeks. Infuse IV over 1 hour.	SC: Dose: 200mg SC once weekly
Inflectra® Remicade® Renflexis®			Induction dose: Infuse IV _____ mg per kg (Dose _____ mg) at 0, 2, and 6 weeks. Other: _____	Maintenance dose: Infuse IV _____ mg per kg (Dose _____ mg) every _____ weeks. Pharmacy to dispense to nearest 100mg vial. Patient to infuse exact dose (do NOT round).
Krystexxa®			8mg IV every 2 weeks as monotherapy (if methotrexate is contraindicated or not clinically appropriate). 8mg IV every 2 weeks with oral methotrexate or folic acid or folic acid supplementation. <ul style="list-style-type: none"> • Begin methotrexate and folic acid/folinic acid at least 4 weeks prior to starting pegloticase. • Oral methotrexate and folic acid/folinic acid to be obtained from retail pharmacy. Labs Q 2 weeks (completed 24-48h prior to next dose) at outpatient lab - D/C Pegloticase if UA>6mg/dL, especially if 2 consecutive levels of >6 mg/dL are observed.	
Orencia®	IV	SC	IV: Infuse _____ mg at weeks 0, 2 and 4, then every 4 weeks thereafter. Other: _____	SC: 125 mg SC once weekly
Saphnelo®			Infuse _____ mg every 4 weeks. Other: _____	
Simponi Aria®	IV	SC	IV: 2mg/kg IV over 30 minutes at weeks 0 and 4, followed by maintenance infusions every 8 weeks. SC: 50 mg SC once monthly	
Rituxan®	Truxima®		Infuse _____ mg intravenously every _____ weeks.	Other: _____
Other:			_____	

PREMEDICATION ORDERS/OTHER MEDICATIONS

Flush Protocol - Flushing per S.A.S.H. protocol (Saline, Administer medication, Saline, Heparin) specific volumes and concentrations based on patient's line type.

Pre-medications 30 minutes prior to start of biologic:
 Acetaminophen _____ mg PO Diphenhydramine (Benadryl) PO _____ Solumedrol _____ mg IV Other: _____