RHEUMATOLOGY ENROLLMENT FORM

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ALTHEA
INFUSION & SPECIALTY PHARMACY™

Patient Name: _____ DOB: / / Height: _____ Weight: _____kg Date: / /

Allergies: _____ Email: _____

Address: _____ Ph: _____

Prescriber: _____ Ph: _____ Fax: _____

Ship to: ☐ Patient ☐ MD Office ☐ Althea Location: _____

Prescriber Signature _____

DOCUMENTS TO INCLUDE WITH REFERRAL

- Patient demographics
- Face sheet
- Insurance information
- **Labs**: TB (Quantiferon or PPD), Hepatitis B & C panel, HIV screening (required prior to initiation of biologics)
- H&P
- Medications and therapies tried and failed
- Baseline assessment, including detailed patient symptoms
- Attach original prescription orders

TB/PPD Test: ☐Positive ☐Negative

DIAGNOSIS

- ☐ 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):

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 1year

OK to round to the nearest vial size.+/- 4 days to allow scheduling flexibility.

SUBCUTANEOUS IMMUNE GLOBULIN PRESCRIPTION (SCIG):

SCIG ____ grams monthly **OR** ____ grams every ____weeks. Refill x 1year. Pharmacy to select number of infusion sites and needle length.

Multiple doses will be administered on consecutive days unless ordered otherwise. ☐ **Non-consecutive days OK**

PRESCRIPTION / DOSAGE AND ADMINISTRATION

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:** 10mg per kg. Dose = _____ 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 folinic acid supplementation. • 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: _____