RHEUMATOLOGY ENROLLMENT FORM

APEXInfusion Ph. (877) 501-6800 F. (877) 501-6844

Date: / /

Ship to:
- ☐ Patient
- ☐ MD Office
- ☐ AIS Location:_____

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

Allergies:_____ Email:_____

Address:_____ Ph:_____

Prescriber:_____ Ph:_____ Fax:_____

PLEASE ATTACH ORIGINAL PRESCRIPTION ORDERS & FAX THE FOLLOWING:

- Patient demographics
- Face sheet
- Insurance information
- Medications and therapies tried and failed
- H&P
- Baseline assessment, including detailed patient symptoms
- Labs:
  - Antibody testing results
  - Most recent BUN/SCr and IgA level
  - EMG/NCV studies

DIAGNOSIS

- ☐ M06.9 - Rheumatoid arthritis
- ☐ M45.9 - Ankylosing spondylitis
- ☐ M32.9 - Systemic lupus erythematosus
- ☐ M08.00 - Unspecified juvenile rheumatoid arthritis
- ☐ L40.0 - Psoriasis vulgaris
- ☐ L40.50 Arthropathic psoriasis, unspecified
- ☐ L40.59 Other psoriatic arthropathy
- ☐ Other (ICD-10 required):_____

TB/PPD Test: ☐ Positive ☐ Negative

IMMUNE GLOBULIN PRESCRIPTION (IVIG)

Loading dose: IVIG ____ gm per kg given over ____ day(s)
OR ____ gm daily for ____ day(s)

Maintenance: IVIG ____ gm per kg given over ____ day(s)
OR ____ gm daily for ____ day(s)

☐ Repeat course every ____ week(s). Refill x 1yr.

SUBCUTANEOUS IMMUNE GLOBULIN PRESCRIPTION (SCIG):

SCIG ____ gm monthly OR ____ gm every ____ weeks. Refill x 1yr.

Pharmacy to select number of infusion sites and needle length.

OK to round to the nearest vial size.

Multiple doses will be administered on consecutive days unless ordered otherwise.

☐ **Non-consecutive days OK**

MEDICATION ORDER	ADMINISTRATION
☐ **Actemra®**	☐ 4 mg/kg IV every 4 weeks ☐ 6 mg/kg IV every 4 weeks ☐ 8 mg/kg IV every 4 weeks ☐ Other:_____
☐ **Benlysta®**	☐ **Induction Dose:** 10 mg per kg. Dose = _____ mg at 2 week intervals for the first 3 doses and at 4 week intervals thereafter. Infuse IV over 1 hour. ☐ **Maintenance Dose:** 10 mg per kg. Dose = _____ mg every 4 weeks. Infuse IV over 1 hour.
☐ **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 100 mg vial. **Patient to infuse exact dose (do NOT round).**
☐ **Krystexxa®**	☐ 8 mg IV every 2 weeks as monotherapy (if methotrexate is contraindicated or not clinically appropriate). ☐ 8 mg 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®**	☐ Infuse _____ mg at weeks 0, 2 and 4, then every 4 weeks thereafter. ☐ **Other:**
☐ **Saphnelo®**	☐ Infuse 300 mg IV every 4 weeks.
☐ **Simponi Aria®**	☐ 2 mg/kg IV over 30 minutes at weeks 0 and 4, followed by maintenance infusions every 8 weeks.
☐ **Rituxan®** ☐ **Truxima®**	☐ Infuse _____ mg intravenously every _____ weeks. ☐ **Other:**
☐ **Other**	

PRE-MEDICATION ORDERS & OTHER MEDICATIONS

Administer pre-medications 30 minutes before every infusion/injection:

- ☐ Acetaminophen (Tylenol) ☐ 500 mg ☐ 650 mg ☐ 1000 mg PO
- ☐ Diphenhydramine (Benadryl) PO ☐ 25 mg ☐ 50 mg
- ☐ Methylprednisolone _____ mg IV
- ☐ Hydration: Solution _____ volume _____ to be infused ☐ Pre OR ☐ Post
- ☐ Other: _____

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