AYSA
THERAPEUTICS INFUSION

RHEUMATOLOGY ORDER FORM

P: 470.395.6076 | F: 470.745.0716

PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: _____ DOB: _____ Phone: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)

MEDICAL INFORMATION

Patient Weight: _____ lbs. Patient Height: _____

Allergies: _____

Previously Failed Therapies: _____ Date: _____

Diagnosis: _____ **(ICD-10)**

- ☐ Iridocyclitic (Uveitis), Unspecified Acute and Subacute
- ☐ Unspecified Iridocyclitis
- ☐ Arthropathic Psoriasis, Unspecified
- ☐ Rheumatoid Arthritis with Rheumatoid Factor, Unspecified
- ☐ Rheumatoid Arthritis without Rheumatoid Factor, Unspecified
- ☐ Rheumatoid Arthritis, Unspecified
- ☐ Ankylosing Spondylitis, Unspecified
- ☐ Gout
- ☐ Systemic Lupus Erythematosus
- ☐ Other: _____

Premedication (if applicable)

- ☐ Tylenol 1000mg PO
- ☐ Benadryl 25-50mg PO/IV
- ☐ Solu-Medrol 125mg IV
- ☐ Pepcid 20mg IV
- ☐ Loratadine 10mg PO **OR** Cetirizine 10mg PO
- ☐ Other: _____

☐ Clinical/Progress Notes, Labs, and Tests supporting primary diagnosis attached

Lab Orders: _____

RHEUMATOLOGY ORDERS

DRUG	DOSING	REFILL
Actemra	☐ 4mg/kg IV every 4 weeks for _____ doses, then followed by 8mg/kg every 4 weeks thereafter ☐ 4mg/kg IV evey 4 weeks ☐ 8mg/kg IV every 4 weeks ☐ Other dose: _____mg IV every 4 weeks	
Cimzia	Initial Dose: 400mg subcutaneously at weeks 0, 2, and 4 weeks Maintenance Dose: ☐ 200mg subcutaneously every 2 weeks ☐ 400mg subcutaneously every 4 weeks	
Krystexxa	☐ 8mg IV in 250mL of NS IV over 120 minutes every 2 weeks *Patient will be observed 1 hour post infusion * Serum Uric Acid required within 72 hours of infusion*	
IVIG	☐ IV ☐ Sub Q ☐ 5% ☐ 10% ☐ _____ % _____ gm/kg IV divided over _____ day(s) _____ mg/kg IV divided over _____ day(s) ☐ Every _____ weeks for one year or _____ one time dose	
Orencia	Orencia Dose: _____mg IV Frequency: ☐ Every 4 weeks OR ☐ 0, 2, 4, weeks, and every 4 weeks thereafter	
SimponiARIA	☐ Initial Dose: 2mg/kg at weeks 0, 4, and then every 8 weeks ☐ Maintenance Dose: 2mg/kg every 8 weeks	
Stelara	☐ Initial Dose: 45mg subcutaneously initially, 4 weeks later, followed by 45mg every 12 weeks ☐ Maintenance Dose: 45mg subcutaneously every 12 weeks ☐ Initial Dose: 90mg subcutaneously initially, 4 weeks later, followed by 90mg every 12 weeks ☐ Maintenance Dose: 90mg subcutaneously every 12 weeks	
Remicade	Dose: _____mg/kg Frequency: ☐ Every _____ weeks ☐ 0, 2, 6, then every 8 weeks	
Rituxan	Dose: 1000mg Frequency: ☐ One time dose ☐ Day 0, repeat dose in 2 weeks	

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing *At Your Service Anesthesia, Inc*., and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Physician Name: _ Date: _____ Phone: _____

Fax: _____ Contact Person: _____