

Patient Name: _____ **Phone:** _____

Physician use only:

DOB: _____ **Patient Weight (in kg):** _____

SIG:

- † **Abatacept** _____ mgs IV on weeks 0, 2, 4 and then every 4 weeks
- † **Belimumab** 10 mgs per kg IV on weeks 0, 2, 4 and then every 4 weeks
- † **Certolizumab Pegol** _____ mg SC on weeks 0, 2, 4 and then every 4 weeks
- † **Denosumab** 60 mg SC every 6 months
- † **Golimumab** 2 mgs per kg IV at weeks 0, 4 and then every 8 weeks
- † **Ibandronate** _____ mg IV
- † **Infliximab** _____ mgs per kg IV @ weeks 0, 2, 6 and then every ____ weeks
- † **Ocrelizumab** _____ 300 mgs IV @ weeks 0, 2 and then 600mg IV every 6 months
- † **Rituximab** _____ mgs IV every _____
- † **Tocilizumab** _____ mg IV every 4 weeks
- † **Ustekinumab** _____ mgs IV @ weeks 0, 4 and then _____ mg IV every ____ weeks
- † **Vedolizumab** _____ mgs per kg IV @ weeks 0, 2, 6 and then every ____ weeks
- † **Other:** _____ † IM or † IV q _____

Premedication?: Yes No

- † **Acetaminophen** _____ mg PO
- † **Diphenhydramine** 25mg IV
- † **Fexofenadine** 180mg PO **Screening labs/tests sent to us**
- † **Methylprednisolone** 40mg IV
- † _____

Dx: _____ **ICD-10 code:** _____

MD Signature: _____ **Date:** _____

Fax this prescription to our office with facesheet/insurance card/requested labs and/or tests (see www.pacificinfusion.com for comprehensive list) & give copy to patient.

