PACIFIC INFUSION CENTER
Friendly • Experienced • Caring

1260 15th Street, Suite 1400
Santa Monica, CA 90404
www.pacificinfusion.com
(310) 297-9269 office
(310) 297-9222 fax

Patient Name: _____ **Phone:**_____

Physician use only: **DOB:** _____**Patient Weight (in kg):** _____

SIG:

- ☐ **Actemra** _____ mg per kg every 4 weeks
- ☐ **Benlysta** 10 mgs per kg IV on weeks 0, 2, 4 and then every 4 weeks
- ☐ **Cimzia** _____mg SC on weeks 0, 2, 4 and then every 4 weeks
- ☐ **Entyvio** _____mgs per kg IV @ weeks 0, 2, 6 and then every ___weeks
- ☐ **Evenity** 210 mg SC every month for 12 months
- ☐ **Ocrevus** _____300 mgs IV @ weeks 0, 2 and then 600mg IV every 6 months
- ☐ **Orencia** _____mgs IV on weeks 0, 2, 4 and then every 4 weeks
- ☐ **Prolia** 60 mg SC every 6 months
- ☐ **Remicade** _____mgs per kg IV @ weeks 0, 2, 6 and then every ___weeks
- ☐ **Rituxan** _____ mgs IV every _____
- ☐ **Simponi Aria** 2 mg per kg IV at weeks 0, 4 and then every 8 weeks
- ☐ **Stelara** _____mgs IV @ weeks 0, 4 and then _____ mg IV every ____ weeks
- ☐ **Other:** _____ ☐ IM or ☐ IV or ☐ SC q _____

Premedication?: ☐ **Yes** ☐ **No**

- ☐ **Acetaminophen** _____mg PO
- ☐ **Diphenhydramine** 25mg IV
- ☐ **Fexofenadine** 180mg PO
- ☐ **Methyprednisolone** 40mg IV
- ☐ _____

☐ **Screening labs/tests sent to us**

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

MD Signature: _____ **Date:** _____

MD Print Name: _____ **Phone Number:** _____

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.