

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
 - Methylprednisolone** 40mg IV
 - _____
- Screening labs/tests sent to us

Dx: _____

ICD-10 code: _____

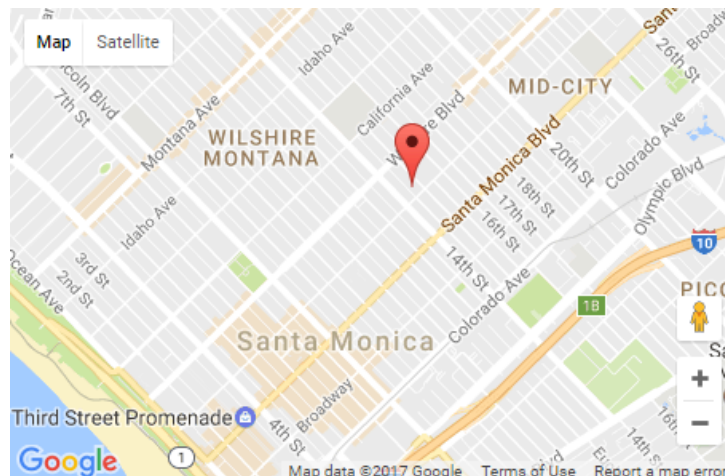
MD Signature: _____

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.



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