PACIFIC INFUSION CENTER
Friendly • Experienced • Caring

450 N. Roxbury Drive Ste 602
Beverly Hills, CA 90210
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 IV 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 _____
- ☐ ☐ **Saphenelo** 300 mgs IV every 4 weeks
- ☐ ☐ **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
- ☐ ☐ _____

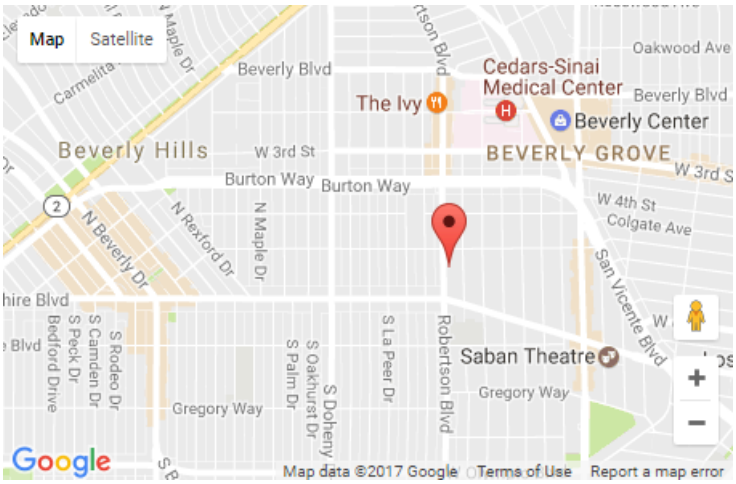
☐ **Screening labs/tests sent to us**

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.



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