BEAUMONT INFUSION CENTERS
RHEUMATOLOGY PRESCRIPTION

Location: ☐ **Royal Oak FAX: 248- 551-3168** ☐ **Troy FAX: 248-964-2409** ☐ **Lenox FAX: 947-523-4061** ☐ **Wayne FAX: 734-467-2505**
☐ **Grosse Pointe FAX: 586-498-4497** ☐ **Farmington Hills FAX: 248-471-8217** ☐ **Dearborn FAX: 313-593-8551**

Patient Name:	**Date of Birth:**	**Medical Record #:**
Physician Name:	**Address:**	**Office #:**
Anticipated Start Date for Care:	**Diagnosis:**	**Diagnosis Code (ICD-10):**

PATIENT INFORMATION

Please attach these *required* documents to Prescription (if not in EPIC):

● Copy of Insurance Card ● Labs ● Supporting clinical documentation ● Patient Demographics

☐ NKDA ☐ Drug Allergies: _____

Height: _____ Weight: _____ kg/lbs Date: _____

REQUIRED LABS FOR THERAPY: To be Ordered By Referring Physician Office

Orencia, Remicade, Simponi Aria, & Actemra: Current TB Test. Date of Test: _____ Result:_____

Rituxan: Hepatitis B Screen (surface antigen and core antibody total required). Date of Test: _____ Result:_____

Actemra: CBC with Diff & Hepatic Screen every 3 Months prior to Infusion. Physician Office to Provide Patient with Prescription/instruction for lab draws at least 72 hours prior to scheduled appointment in the infusion center

MEDICATION	DOSE	# Doses
ABATACEPT (ORENCIA)	**Dosage:** **Body weight of Patient** / **Dose** / **Number of Vials** ☐ <60 kg — 500 mg — 2 vials ☐ 60-100 kg — 750 mg — 3 vials ☐ >100 kg — 1000 mg — 4 vials ☐ Initial Dosing on Day 1, 15, and 30. Infuse over 30 minutes. ☐ Maintenance Dose every 4 weeks. Infuse over 30 minutes.	
BELIMUMAB (BENLYSTA)	10 mg/kg x _____ kg = _____ mg IV over one hour. Observe for 30 minutes post infusion. ☐ Initial Dosing on Day 1, Day 15, and Day 29. ☐ Maintenance Dosing every 4 weeks.	
GOLIMUMAB (SIMPONI ARIA)	2 mg/kg x _____ kg = _____ mg IV over 30 minutes. **Frequency:** ☐ Initial Dose at 0 and 4 weeks ☐ Maintenance Dosing every 8 weeks.	
INFLIXIMAB (REMICADE)	_____ mg/kg x _____ kg = _____ mg (rounded to the nearest 100 mg). ☐ Induction dosing at 0, 2, and 6 weeks. ☐ Maintenance Dosing every _____ weeks. ☐ Traditional Infusion Rate. Infuse over NO LESS THAN 2 HOURS. ☐ Rapid Infusion Rate: Infuse over 60 minutes. Per hospital guidelines, one hour infusions are permitted pursuant to a prescriber-order in pediatric and adult outpatients who have previously received at least 4 infliximab infusions without infusion reactions. **Pre Medications:** ☐ Acetaminophen ☐ 325mg, ☐ 500 mg, ☐ 650 mg, ☐ 1000 mg PO ½ hour prior to infusion. ☐ Diphenhydramine 25mg PO ½ hour prior to infusion.	
RITUXIMAB (RITUXAN)	1000 mg IV on Day 1 and Day 15. • 1st infusion: Initiate at 50mg/hour. If no reaction, increase to 50mg/hr every 30 minutes to a maximum of 400mg/hour. • Subsequent Infusions: If no reaction on first infusion, infuse at 100mg/hour and increase by 100mg/hour every 30 minutes to a maximum infusion rate of 400mg/hour. Pre-Medications: ☐ Acetaminophen ☐ 325mg, ☐ 500 mg, ☐ 650 mg, ☐ 1000 mg PO 30 minutes prior to infusion. ☐ Diphenhydramine 25mg PO 30 minutes prior to infusion. ☐ Methylprednisolone 100 mg IV 30 minutes prior to infusion.	
TOLILIZUMAB (ACTEMRA)	☐ 4mg/kg x _____kg = _____ mg IV over 1 hour every 4 weeks. Maximum Dose 800 mg. ☐ 8mg/kg x _____kg = _____ mg IV over 1 hour every 4 weeks. Maximum Dose 800 mg.	
• Adult Anaphylaxis Protocol. Notify physician if reaction occurs. • 250 ml 0.9% Sodium Chloride flush bag with infusion as needed.		

INFUSION RATE			
TIME (min)	**INFUSION RATE**	**TIME (min)**	**INFUSION RATE**
0	Initiate at 10 ml/hr	60	Increase to 150 ml/hr
15	Increase to 20 ml/hr	90	Increase to 250 ml/hr
30	Increase to 40 ml/hr	120	End of Therapy
45	Increase to 80 ml/hr		

Physician Signature _____ **Beeper #**_____ **Date** _____ **Time** _____

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