

**BEAUMONT INFUSION CENTERS
RHEUMATOLOGY PRESCRIPTION**

Location / Royal Oak : 248- 551-3168 Troy : 248-964-2409 Lenox : 947-523-4061 Wayne : 734-467-2505
 Fax Number Grosse Pointe : 586-498-4497 Farmington Hills : 248-471-8217 Dearborn : 313-593-5802 Livonia : 734-542-3356

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: _____

Rituximab/Simponi Aria/Infliximab/Actemra: Hepatitis B screening completed and patient is clear to receive treatment Yes No

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)	<p>Dosage: <u>Body weight of Patient</u> <u>Dose</u> <u>Number of Vials</u></p> <p><input type="checkbox"/> <60 kg 500 mg 2 vials</p> <p><input type="checkbox"/> 60-100 kg 750 mg 3 vials</p> <p><input type="checkbox"/> >100 kg 1000 mg 4 vials</p> <p><input type="checkbox"/> Initial Dosing on Day 1, 15, and 30. Infuse over 30 minutes.</p> <p><input type="checkbox"/> Maintenance Dose every 4 weeks. Infuse over 30 minutes.</p> <p>Observe patient for 30 minutes after each infusion.</p>	
BELIMUMAB (BENLYSTA)	<p>10 mg/kg x _____ kg = _____ mg IV over one hour. Observe for 30 minutes post infusion.</p> <p><input type="checkbox"/> Initial Dosing on Day 1, Day 15, and Day 29.</p> <p><input type="checkbox"/> Maintenance Dosing every 4 weeks.</p>	
GOLIMUMAB (SIMPONI ARIA)	<p>2 mg/kg x _____ kg = _____ mg IV over 30 minutes.</p> <p>Frequency: <input type="checkbox"/> Initial Dose at 0 and 4 weeks <input type="checkbox"/> Maintenance Dosing every 8 weeks.</p>	
INFLIXIMAB (REMICADE)	<p>_____ mg/kg x _____ kg = _____ mg (rounded to the nearest 100 mg).</p> <p><input type="checkbox"/> Induction dosing at 0, 2, and 6 weeks.</p> <p><input type="checkbox"/> Maintenance Dosing every _____ weeks.</p> <p><input type="checkbox"/> Traditional Infusion Rate. Infuse over NO LESS THAN 2 HOURS. For the first dose and for patients with a history of infusion reaction: Begin infusion at 10mL/hr for 15 minutes, then 20mL/hr for 15 minutes, then 40mL/hr for 15 minutes, then 80mL/hr for 15 minutes, then 150mL/hr for 30 minutes, then 250mL/hr until infusion complete. For subsequent infusions: If patient tolerates infusion, may infuse over 2 hours without titration.</p> <p><input type="checkbox"/> 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.</p> <p>Pre Medications:</p> <p><input type="checkbox"/> Acetaminophen <input type="checkbox"/> 325mg, <input type="checkbox"/> 500 mg, <input type="checkbox"/> 650 mg, <input type="checkbox"/> 1000 mg PO ½ hour prior to infusion.</p> <p><input type="checkbox"/> Diphenhydramine 25mg PO ½ hour prior to infusion.</p>	
RITUXIMAB (RITUXAN)	<p>1000 mg IV on Day 1 and Day 15.</p> <ul style="list-style-type: none"> • 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. <p>Pre-Medications:</p> <p><input type="checkbox"/> Acetaminophen <input type="checkbox"/> 325mg, <input type="checkbox"/> 500 mg, <input type="checkbox"/> 650 mg, <input type="checkbox"/> 1000 mg PO 30 minutes prior to infusion.</p> <p><input type="checkbox"/> Diphenhydramine 25mg PO 30 minutes prior to infusion.</p> <p><input type="checkbox"/> Methylprednisolone 100 mg IV 30 minutes prior to infusion.</p>	
TOLILIZUMAB (ACTEMRA)	<p><input type="checkbox"/> 4mg/kg x _____ kg = _____ mg IV over 1 hour every 4 weeks. Maximum Dose 800 mg.</p> <p><input type="checkbox"/> 8mg/kg x _____ kg = _____ mg IV over 1 hour every 4 weeks. Maximum Dose 800 mg.</p>	
<ul style="list-style-type: none"> • Adult Anaphylaxis Protocol. Notify physician if reaction occurs. • 250 ml 0.9% Sodium Chloride flush bag with infusion as needed. 		

Physician Signature _____ Beeper # _____ Date _____ Time _____