



Friendly ♦ Experienced ♦ Caring

5170 Sepulveda Blvd Ste 100
Sherman Oaks, CA 91403
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 IV every 4 weeks
- Avsola** _____ mgs per kg IV @ weeks 0, 2, 6 and then every ___ 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** 300 mgs per kg IV @ weeks 0, 2, 6 and then every ___ weeks
- Evenity** 210 mg SC every month for 12 months
- Ilumya** 100 mgs SC @ weeks 0, 4 and then 100 mg SC every 12 weeks
- Leqembi** 10 mgs per kg IV every 2 weeks
- Ocrevus** 300 mgs IV @ weeks 0, 2 and then 600mg IV every 6 months
- Omvoh** 300 mgs IV @ weeks 0, 4 and 8
- 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
- Renflexis** _____ mgs per kg IV @ weeks 0, 2, 6 and then every ___ weeks
- Rituxan** _____ mgs IV every _____
- Saphenelo** 300 mgs IV every 4 weeks
- Skyrizi** 600 mgs per kg IV @ weeks 0, 4, 8
- 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 **Screening labs/tests sent to us**
- Methyprednisolone** 40mg IV 125mg Other: _____
- _____

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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