

**Patient Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

Physician use only:

**DOB:** \_\_\_\_\_ **Patient Weight (in kg):** \_\_\_\_\_

**SIG:**

- Actemra** \_\_\_\_\_ mg per kg 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
- Cosentyx** 6 mg on week 0 as a loading dose then 1.75 mg per kg every 4 weeks
- Cosentyx** 1.75 mg every 4 weeks (without loading dose)
- Entyvio** 300 mgs 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
- Kisunla** 700 mgs IV @ weeks 0, 4 and 8 then 1400 mg every 4 weeks
- Leqembi** 10 mgs per kg IV every 2 weeks
- Leqvio** 284 mgs SC on week 0, then at 3 months then every 6 months
- 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
- Simponi Aria** 2 mg per kg IV at weeks 0, 4 and then every 8 weeks
- Skyrizi** 600 mgs IV @ weeks 0, 4, 8 (Crohn's Disease)
- Skyrizi** 1200 mgs IV @ weeks 0, 4, 8 (Ulcerative Colitis)
- Stelara** \_\_\_\_\_ mgs IV @ weeks 0, 4 and then \_\_\_\_\_ mg IV every \_\_\_\_\_ weeks
- Tepezza** 10 mgs per kg IV @ weeks 0, 2 and then 300 mg per kg IV every 6 months
- Tremfya** 200 mgs IV @ weeks 0, 4, 8
- Uplizna** 300 mgs @ weeks 0, 2 and then 300mg every 6 months from week 0
- 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](http://www.pacificinfusion.com) for comprehensive list) & give copy to patient.