PACIFIC INFUSION CENTER
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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 an then 20 mg per kg IV every 3 weeks
- ☐ ☐ **Tremfya** 200 mgs IV @ weeks 0, 4, 8 (Induction dose for Ulcerative Colitis and Crohn's Disease)
- ☐ ☐ **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: _____ MD Print Name: _____

Date: _____ Phone Number: _____ Fax 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.