

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
- Gazyva** 1000 mg IV @ weeks 0, 2, 24, 26 then every 6 weeks
- 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
- Ocrevus Zunovo** 23mL SC 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)
- Stoboclo** 60 mg SC every 6 months
- 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 _____
- Do not substitute**

Premedication?: Yes No

- Acetaminophen** _____ mg PO
- Diphenhydramine** 25mg IV
- Fexofenadine** 180mg PO **Screening labs/tests sent to us**
- Methylprednisolone** 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.