



Cascade Infectious Diseases and Infusion

Specialty Order Form

Patient: _____	Ordering Provider: _____
DOB: _____ <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ lbs.	NPI: _____
Height: _____ ICD-10 Code(s): _____	Practice: _____
Diagnosis: _____	Phone: _____
Allergies: _____	Fax: _____
Primary Care Provider: _____	Contact Name: _____

Has the patient been treated for this condition previously? No Yes, medication(s): _____

Is the patient currently on therapy? No Yes, medication(s): _____

ACTEMRA (TOCILIZUMAB) 20 mg/mL (vial sizes: 4 mL, 10 mL, 20 mL) *maximum dose per infusion 800 mg*

- Initial Dose: 4 mg/kg: _____ mg IV every 4 weeks, infusion over 60 minutes
- Maintenance Dose: 8 mg/kg: _____ mg every 4 weeks, infusion over 60 minutes
- Alternative Dosage: _____

ORENCIA IV (ABATACEPT) 250 mg vial for IV *dosage based on patient's weight in kg*

- Less than 60 kg, dose: 500 mg 60-100 kg, Dose: 750 mg Greater than 100 kg, dose: 1000 mg
- New Start: IV Infusion at week 0, week 2, week 4, then:
- Maintenance Dose IV Infusion every 4 weeks

REMICADE (INFLIXIMAB) 100 mg vial

- New Start: _____ mg/kg _____ mg IV on week 0, week 2, week 6, then:
- Maintenance Dose: _____ mg/kg _____ mg IV every _____ weeks for _____ infusions

In the event insurance does not authorize Remicade, permission is granted to change the patient's therapy to Biosimilar Infliximab (Inflectra or Renflexis) if selected, please fill out information below:

BIOSIMILAR INFLIXIMAB: AVSOLA 100 mg vial INFLECTRA 100 mg vial RENFLEXIS 100 mg vial

- New Start: _____ mg/kg _____ mg IV on week 0, week 2, week 6, then:
- Maintenance Dose: _____ mg/kg _____ mg IV every _____ weeks for _____ infusions

RITUXAN (RITUXIMAB) 1000 mg vial **BIOSIMILAR RITUXIMAB:** TRUXIMA 1000 mg vial

- Day 1 IV infusion Day 15 IV infusion (will dispense available vial size)
- Other: _____

SIMPONI ARIA (GOLIMUMAB) 50 mg/ 4 mL single-use vial

- Initial Dose: 2 mg/kg: _____ mg IV at weeks 0 and 4, infusion over 30 minutes
- Maintenance Dose: 2 mg/kg: _____ mg IV every 8 weeks, infusion over 30 minutes
- Alternate Dosage: _____

ENTYVIO (VEDOLIZUMAB)

- New Start: 300 mg vial IV on: week 0, week 2, week 6, then:
- Maintenance Dose: 300 mg vial IV every 8 weeks

Pre-medication(s): _____

Labs/ Frequency: _____

Physician's Signature: _____ Date: _____