Denver Arthritis Clinic

INFUSION ORDER SET

P: (303) 302-7426 | **F:** (720) 862-0405

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to (720) 862-0405

Patient Name:_____ DOB: _____ Phone:_____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:**

MEDICAL INFORMATION:

Patient Weight:_____ lbs. Patient Height: _____ Allergies: _____

ICD-10: _____ Diagnosis:

- ☐ Rheumatoid Arthritis
- ☐ Osteoporosis
- ☐ Psoriatic Arthritis
- ☐ Rheumatoid Arthritis with Rheumatoid Factor
- ☐ ANCA vasculitis
- ☐ Ankylosing Spondyiitis
- ☐ Gout
- ☐ Systemic Lupus Erythematosus
- ☐ Multiple Sclerosis Relapsing Remitting
- ☐ Multiple Sclerosis Primary Progressive
- ☐ Ulcerative Colitis
- ☐ Thyroid Eye Disease
- ☐ Crohn's Disease
- ☐ Plaque Psoriasis
- ☐ Other: _____

THERAPY ORDER

Drug	Dosing
Actemra	☐ 4 mg/kg IV every 4 weeks ☐ 6 mg/kg IV every 4 weeks ☐ 8mg/kg IV every 4 weeks ☐ Other: _____
Benlysta	☐ Initial Dose: 10 mg/kg every 2 weeks for 3 doses then every 4 weeks **OR** ☐ Maintenance: 10 mg/kg every 4 weeks
Briumvi	☐ Loading Dose: 150 mg IV, followed by 450 mg IV 2 weeks later then 450 mg every 24 weeks **OR** ☐ 450 mg IV every 24 weeks
Cimzia	☐ Initial Dose: 400 mg SQ at weeks 0, 2, and 4 weeks followed by: ☐ 200 mg SQ every 2 weeks **OR** ☐ 400 mg SQ every 4 weeks
Cosentyx	☐ 300 mg at weeks 0,1,2,3,4 followed by 300 mg every 4 weeks **OR** Weight based ☐ Loading: 6 mg/kg at week 0 followed by 1.75mg/kg (300 mg max) every 4 weeks ☐ Without Loading: 1.75mg/kg every 4 weeks
Entyvio	☐ Initial Start: 300 mg IV at 0, 2, 6 then every 8 weeks **OR** ☐ 300 mg IV every 8 weeks
Evenity	☐ 210 mg once monthly x 1 year
Ilumya	☐ Initial Dose: 100 mg SQ at weeks 0, 4 and every 12 weeks **OR** ☐ Maintenance Dose: 100mg SQ every 12 weeks
Infliximab (Remicade/Avsola/ Renflexis)	☐ Infuse Remicade OR infliximab biosimilar as required by patient's insurance **OR** ☐ Do not substitute. Infuse the following infliximab product: _____ Dose: _____ mg/kg **AND** Frequency: ☐ 0, 2, 6 weeks, then every _____ weeks ☐ Every _____ weeks (maintenance dose) ☐ Other _____
Krystexxa	☐ Dose: 8mg IV every 2 weeks

Nulojix	☐ Initial phase: IV: 10 mg/kg on day 1 (day of transplant, prior to implantation) and on day 5 (-96 hours after day 1 dose), followed by 10 mg/kg at the end of week 2, week 4, week 8, and week 12 following transplantation **OR** ☐ Maintenance phase: IV: 5 mg/kg every 4 weeks beginning at the end of week 16 following transplantation **OR** Other: _____
Ocrevus	☐ Loading Dose: 300mg IV at 0 and 2 weeks, then 600mg IV every 6 months OR ☐ 600mg IV every 6 months
Orencia	☐ Dose: _____ mg IV (<60 kg: 500 mg; 60 to 100 kg: 750 mg; >100 kg: 1 g) **AND** Frequency: ☐ 0, 2, 4 weeks, and every 4 weeks ☐ Every 4 weeks
Prolia	☐ 60 mg SQ every 6 months
Reclast (Zoledronic Acid)	☐ 5 mg IV x 1
Rituximab (Rituxan/Truxima/Ruxience)	☐ Infuse Rituxan OR rituximab biosimilar as required by patient's insurance **OR** ☐ Do not substitute. Infuse the following rituximab product: _____ **AND** DOSE: ☐ 1000mg ☐ 375mg/m2 ☐ 500mg **AND** Frequency: ☐ One time dose ☐ Day 0, repeat dose in 2 weeks, then repeat course every _____ weeks OR _____ months x _____ refill(s) ☐ Day 0, repeat dose in 2 weeks. One time order, do not repeat the course. ☐ Weekly x 4 weeks ☐ Every 6 months x _____ refill(s) ☐ Other: _____
Saphnelo	☐ 300mg IV every 4 weeks
Simponi Aria	☐ 2mg/kg IV at weeks 0, 4, and then every 8 weeks (initial dosing) **OR** ☐ 2mg/kg IV every 8 weeks x 1 year
Stelara	Initial Infusion: ☐ ≤55kg (<120 lbs) 260 mg IV x 1 dose ☐ 55kg to 85kg (121 lbs. to 187 lbs.) 390mg IV x 1 dose ☐ >85kg (>187lbs.) 520mg IV x 1 dose
Tepezza	☐ 10mg/kg IV for the first infusion, followed by 20mg/kg IV (3 weeks after the initial dose) every 3 weeks for 7 additional infusions (8 total infusions)
Vyepti	☐ 100mg IV every 3 months **OR** ☐ 300mg IV every 3 months
Other/Specific Instructions: _____	Dose: _____ Frequency: _____

Premedication orders: Tylenol ☐ 1000mg ☐ 500mg PO

☐ Diphenhydramine 25-50mg PO/IV ☐ Loratadine 10mg PO ☐ Cetirizine 10mg ☐ Cetirizine 10mg IVP

Additional premedications: ☐ Solu-Medrol_____mg IVP ☐ Solu Cortef_____mg IVP ☐ Other_____

Lab orders: _____ **Lab frequency:** _____

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing DAC and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies and to select the preferred site of care for the patient:

Provider Name:_____ Signature:_____Date: _____

Provider NPI: _____Phone:_____ Fax: _____ Contact Person:_____

PREFERRED LOCATION

☐ Lowry Denver, CO
7111 E Lowry Blvd #200, Denver CO 80230

☐ Lone Tree, CO
9695 S Yosemite St #120, Lone Tree, CO 80124

DAC
Denver Arthritis Clinic

INFUSION CENTER AT DAC

PATIENT INFORMATION: Fax completed form, insurance information, and clinical documentation to (720) 862-0405

Patient Name:_____ DOB:_____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

☐ Include signed and completed order (MD/prescriber to complete page 1)

☐ Include patient demographic information and insurance information

☐ Include patient's medication list

☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

- ☐ For biologic orders, has the patient had a documented contraindication/intolerance or failed trail of a conventional therapy (i.e., steroids)? ☐ Yes ☐ No
  If yes, which drug(s)? _____
- ☐ For biologic orders, does the patient have a contraindication/intolerance or failed trial to any other biologic? ☐ Yes ☐ No
  If yes, which drug(s)? _____

☐ Include labs and/or test results to support diagnosis

☐ If applicable - Last known biologic therapy:_____ and last date received: _____. If patient is switching to biologic therapies, please perform a wash-out period of _____weeks prior to starting ordered biologic therapy.

☐ Other medical necessity: _____

REQUIRED PRE-SCREENING (DRUG THERAPY)

☐ **TB screening test completed within 12 months - attach results**
☐ **Positive** ☐ **Negative**

☐ **Hepatitis B screening (Hepatitis B surface antigen) -** ☐ **Positive** ☐ **Negative**

Hepatitis B core antibody total (not IgM) - ☐ **Positive** ☐ **Negative**

☐ **Serum immunoglobulins - attach results** Recommended for: rituximab

*If TB or Hepatitis B results are positive - please provide documentation of treatment or medical clearance, and a negative CXR (TB+)

Denver Arthritis Clinic will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (720) 862-0405 or call (303) 302-7426