RHEUMATOLOGY INFUSION REFERRAL FORM

BURNHAM'S vitalcare

PATIENT INFORMATION

Last Name	First Name	
DOB	Patient Phone	
Allergies	Height	Weight
Vascular Access Method ☐ Peripheral ☐ Central ☐ Other: _____	Lab Orders	

PRESCRIBER INFORMATION

Physician Name		DEA #:
Physician Signature		Date
Phone		Fax
City	State	Zip Code

PRESCRIPTION INFORMATION

MEDICATION	ROUTE	DOSE/STRENGTH	DIRECTIONS	QTY	REFILLS
☐ Benlysta	☐ IV	☐ 10 mg/kg	Starting Dose ☐ 10 mg/kg IV at week 0, 2, 4 and then every ___ weeks Maintenance Dose ☐ 10 mg/kg IV every ___weeks	☐ 1 month ☐ 3 months ☐ _____	☐ 1 year
☐ Cimzia	☐ IV	☐ 200 mg prefilled syringe ☐ 200 mg lyophilized powder vial	Starting Dose ☐ 400 mg (given as two 200 mg subcutaneous injections) at weeks 0, 2, and 4 Maintenance Dose ☐ 200 mg subcutaneous injection every other week ☐ Other _____	☐ 1 month ☐ 3 months ☐ _____	☐ 1 year
☐ Immune Globulin	☐ IV ☐ SUBQ	☐ ____ g ☐ ____ g	☐ 1 mg/kg/hr for first 30 minutes then increase every 30 minutes to a max rate of 6 mg/kg/hr not to exceed 300 mL/hr	☐ 1 month ☐ 3 months ☐ _____	☐ 1 year ☐ _____
☐ Orencia (abatacept)	☐ IV	☐ 500 mg Orencia ☐ 750 mg Orencia ☐ 1000 mg Orencia	☐ Infuse over 30 minutes	☐ 1 month ☐ 3 months ☐ _____	☐ 1 year ☐ _____
☐ Remicade (infliximab) Biosimilars: ☐ Avsola ☐ Inflectra ☐ Infliximab ☐ Renflexis	☐ IV	Starting Dose (100 mg vial) ☐ None ☐ 5 mg/kg x Pt weight ___(kg) = ____ mg IV every 8 weeks Maintenance Dose ☐ 5 mg/kg x Pt weight ___(kg) = ____ mg IV every 8 weeks	☐ Reconstitute each vial with 10 mL of sterile water. Dilute desired dose in 250 mL to be infused over a period NOT less than 2 hours. ☐ Additional directions (include daily, weekly, cyclic, one-time, duration of therapy, etc.) _____ _____	☐ 1 month ☐ 3 months ☐ _____	☐ 1 year ☐ _____
☐ Rituximab	☐ IV	☐ 1000 mg IV on day 0, 14 then repeat the course every ___ weeks ☐ 375 mg/m2 IV every 4 weeks ☐ Other _____	☐ Infuse as directed	☐ 1 month ☐ 3 months ☐ _____	☐ 1 year ☐ _____
☐ Stelara (Ustekinumab)	☐ IV ☐ SUBQ	Starting Dose ☐ 130 mg/26 mL Vial Pt Current Weight _____ Maintenance Dose ☐ 90 mg/1 ml (may substitute with 45 mg vials)	Infuse: ☐ 55 kg: 260 mg IV as a single dose ☐ > 55 kg to 85 kg: 390 mg IV as a single dose ☐ > 85 kg: 520 mg IV as a single dose ☐ Inject 90 mg SubQ 8 weeks after first IV dose, then every 8 weeks thereafter	☐ 2 ☐ 3 ☐ 4 ☐ 1 x 90 mg or 2 x 45 mg	☐ 1 year
☐ Simponi Aria (golimumab)	☐ IV	Starting Dose ☐ 2 mg/kg x Pt weight ___(kg) = ____ mg IV at week 0, 4 ☐ Other _____ Maintenance Dose ☐ 2 mg/kg x Pt weight ___(kg) = ____ mg IV every 8 weeks ☐ Other _____	☐ Infuse diluted solution over a period of 30 minutes	☐ 1 month ☐ 3 months ☐ _____	☐ 1 year ☐ _____

If you would like to send this referral to Burnham's Vital Care, you may fax this form to (228) 474-5545.
If you have any questions, please call us at (228) 474-4663.