4704 Cahaba River Road, Suite 101-D, Bham, AL 35243

Phone: (205) 739-2266 Fax: (205) 490-8663 Bhaminfusion.com

ACTEMRA (Tocilizumab) Infusion Order

Patient Name (Print) _____ DOB _____

Phone _____ Patient Weight _____

*Please attach demographics, clinic notes & labs (Hep B, Qgold or Chest X-ray).

DIAGNOSIS (Please provide ICD-10 code):

_____ Rheumatoid Arthritis _____ Giant Cell Arthritis _____ _____ (other)

_____ Cytokine Release Syndrome _____ Polyarticular Idiopathic Arthritis ____ SJIA Arthritis

PRE-MEDICATION (IF NEEDED):

_____ Tylenol 1000mg PO _____ Solu-Cortef 100mg IVP _____ _____ (other)

_____ Pepcid 20mg PRN _____ Benadryl 25-50mg PRN

ACTEMRA ORDERS/DOSAGE:

____ Initial dose of 4mg/kg every 4 weeks for ____ treatments & then 8mg/kg every 4 weeks

____ 4mg/kg every 4 weeks

____ 8mg/kg every 4 weeks ____ _____ (other)

PHYSICIAN NOTES: _____

ORDERING PROVIDER (Print Name): _____

Signature: _____ Date: _____

Phone: _____ Fax: _____

Birmingham ID & Infusion

4704 Cahaba River Road, Suite 101-D, Bham, AL 35243

Phone: (205) 739-2266 Fax: (205) 490-8663 Bhaminfusion.com

BENLYSTA (Belimumab) Infusion Order

Patient Name (Print) _____ DOB _____

Phone _____ Patient Weight _____

*Please attach demographics, clinic notes & labs (Hep B, Qgold or Chest X-ray).

DIAGNOSIS (Please provide ICD-10 code):

____ Systemic Lupus Erythematosus ____ _____ (other)

PRE-MEDICATION (IF NEEDED):

_____ Tylenol 1000mg PO _____ Solu-Cortef 100mg IVP _____ _____ (other)

_____ Pepcid 20mg PRN _____ Benadryl 25-50mg PRN

BENLYSTA ORDERS/DOSAGE: _____ 10mg/kg IV

FREQUENCY: ____ Dose at 2 & 4 weeks & then every 4 weeks ____ Dose every 4 weeks

____ _____(other)

PHYSICIAN NOTES: _____

ORDERING PROVIDER (Print Name): _____

Signature: _____ Date: _____

Phone: _____ Fax: _____

Birmingham
ID & Infusion

4704 Cahaba River Road, Suite 101-D, Birmingham. AL 35243

Phone (205) 739-2266 Fax (205) 490-8663 Bhaminfusion.com

REMICADE (Infliximab) Infusion Order

Patient Name _____ Male____ Female____

DOB _____ Phone _____ Patient Weight _____

* Please attach demographics, clinic notes & labs (Hep B, Qgold or Chest X-ray).

DIAGNOSIS (Please provide ICD-10 code):

_____ Rheumatoid Arthritis _____ Ankylosing Spondylitis _____ _____

_____ Psoriatic Arthritis _____ Crohn's Disease

_____ Plaque Psoriasis _____ Ulcerative Colitis

PRE-MEDICATION

_____ Tylenol 1000mg PO _____ Solu-Cortef 100mg IVP _____ _____

_____ Pepcid 20mg IV PRN _____ Benadryl 50mg PRN

REMICADE ORDERS

Dosage: _____ mg/kg (Weight Based) _____ mg (Flat Dosed)

Frequency: ____ Every 0,2,6 and 8 weeks (induction) ____ Every _____ weeks

PHYSICIAN NOTES: _____

ORDERING PROVIDER (Print Name): _____

Signature: _____ Date: _____

Phone: _____ Fax: _____

Birmingham
ID & Infusion

4704 Cahaba River Road, Suite 101-D, Bham, AL 35243

Phone: (205) 739-2266 Fax: (205) 490-8663 Bhaminfusion.com

RENFLEXIS (Infliximab-abda) Infusion Order

Patient Name (Print) _____ DOB _____

Phone _____ Patient Weight _____

*Please attach demographics, clinic notes & labs (Hep B, Qgold or Chest X-ray).

DIAGNOSIS (Please provide ICD-10 code):

____ Rheumatoid Arthritis ____ Psoriatic Arthritis ____ Plaque Psoriasis
____ Crohn's Disease ____ Ulcerative Colitis ____ Ankylosing Spondylitis
____ _____ (other)

PRE-MEDICATION (IF NEEDED):

_____ Tylenol 1000mg PO _____ Solu-Cortef 100mg IVP _____ _____ (other)

_____ Pepcid 20mg PRN _____ Benadryl 25-50mg PRN

RENFLEXIS ORDERS/DOSAGE: _____ mg/kg (weight based) _____ mg (flat-dosed)

FREQUENCY: ____ Every 2, 6 & then 8 weeks ____ Every _____ weeks

____ _____(other)

PHYSICIAN NOTES: _____

ORDERING PROVIDER (Print Name): _____

Signature: _____ Date: _____

Phone: _____ Fax: _____

Birmingham
ID & Infusion

4704 Cahaba River Road, Suite 101-D, Birmingham. AL 35243

Phone (205) 739-2266 Fax (205) 490-8663 Bhaminfusion.com

KRYSTEXXA (Pegloticase) Order

Patient Name _____ DOB _____

Phone _____ Patient Weight _____ Height _____

*Please attach demographics, clinic notes & labs (uric acid level).

DIAGNOSIS (Please provide ICD-10 code):

_____ Chronic Gout _____ _____ (other)

PRE-MEDICATION (IF NEEDED):

_____ Tylenol 1000mg PO _____ Solu-Cortef 100mg IVP _____ _____

_____ Pepcid 20mg IV PRN _____ Benadryl 50mg PRN

ORDERS/DOSAGE:

_____ 8mg IV every 2 weeks _____ _____ (other)

PHYSICIAN NOTES: _____

ORDERING PROVIDER (Print Name): _____

Signature: _____ Date: _____

Phone: _____ Fax: _____

Birmingham ID & Infusion

4704 Cahaba River Road, Suite 101-D, Bham, AL 35243

Phone: (205) 739-2266 Fax: (205) 490-8663 Bhaminfusion.com

ORENCIA (Abatacept) Infusion Order

Patient Name (Print) _____ DOB _____

Phone _____ Patient Weight _____

*Please attach demographics, clinic notes & labs (Hep B, Qgold or Chest X-ray).

DIAGNOSIS (Please provide ICD-10 code):

____ Rheumatoid Arthritis ____ Polyarticular Idiopathic Arthritis ____ _____ (other)

PRE-MEDICATION (IF NEEDED):

_____ Tylenol 1000mg PO _____ Solu-Cortef 100mg IVP _____ _____ (other)

_____ Pepcid 20mg PRN _____ Benadryl 25-50mg PRN

ORENCIA ORDERS/DOSAGE: _____ 500mg _____750mg _____1000mg

FREQUENCY: ____ Every 2 & 4 weeks then every 4 weeks ____ Every ____ weeks

____ _____(other)

PHYSICIAN NOTES: _____

ORDERING PROVIDER (Print Name): _____

Signature: _____ Date: _____

Phone: _____ Fax: _____

Birmingham
ID & Infusion

4704 Cahaba River Road, Suite 101-D, Birmingham. AL 35243

Phone (205) 739-2266 Fax (205) 490-8663 Bhaminfusion.com

PROLIA Injection Order

Patient Name _____ DOB _____

Phone _____ Patient Weight _____ Height _____

*Please attach demographics, clinic notes and labs (DEXA, calcium & vitamin D).

DIAGNOSIS (Please provide ICD-10 code):

_____ Age-related osteoporosis **without/with** (please circle) current pathological fracture

_____ Cancer treatment-induced bone loss/CTIBL-HALT _____ _____(Other)

*Osteopenia is not a billable diagnosis.

LIST ALL MEDICATIONS PATIENT HAS TRIED & FAILED: _____

ORDERS/DOSAGE:

_____ 60mg SQ every six months _____ _____ (Other)

PHYSICIAN NOTES: _____

ORDERING PROVIDER (Print Name): _____

Signature: _____ Date: _____

Phone: _____ Fax: _____

Birmingham
ID & Infusion

4704 Cahaba River Road, Suite 101-D, Birmingham. AL 35243

Phone (205) 739-2266 Fax (205) 490-8663 Bhaminfusion.com

RECLAST (Zoledronic Acid) Order

Patient Name _____ DOB _____

Phone _____ Patient Weight _____ Height _____

*Please attach demographics, clinic notes & labs (DEXA, creatinine, calcium, vitamin D).

DIAGNOSIS (Please provide ICD-10 code):

_____ Osteoporosis _____ Senile Osteoporosis _____ Paget's Disease of the Bone

_____ Glucocorticoid-induced Osteoporosis _____ _____ (other)

PRE-MEDICATION (IF NEEDED):

_____ Tylenol 1000mg PO _____ Solu-Cortef 100mg IVP _____ _____

_____ Pepcid 20mg IV PRN _____ Benadryl 50mg PRN

ORDERS/DOSAGE:

_____ _____mg every _____ **weeks / years** (circle one) _____ _____(other)

PHYSICIAN NOTES: _____

ORDERING PROVIDER (Print Name): _____

Signature: _____ Date: _____

Phone: _____ Fax: _____

Birmingham
ID & Infusion

4704 Cahaba River Road, Suite 101-D, Bham, AL 35243

Phone: (205) 739-2266 Fax: (205) 490-8663 Bhaminfusion.com

RITUXAN (Rituximab) Infusion Order

Patient Name (Print) _____ DOB _____

Phone _____ Patient Weight _____

*Please attach demographics, clinic notes & labs (Hep B, Qgold or Chest X-ray).

DIAGNOSIS (Please provide ICD-10 code):

_____ Rheumatoid Arthritis _____ Microscopic Polyangiitis _____ _____ (other)

_____ Granulomatosis w/ Polyangiitis (Wegener's)

PRE-MEDICATION (IF NEEDED):

_____ Tylenol 1000mg PO _____ Solu-Cortef 100mg IVP _____ _____ (other)

_____ Pepcid 20mg PRN _____ Benadryl 25-50mg PRN

RITUXAN ORDERS/DOSAGE: ____ 1,000mg ____375mg/m2

FREQUENCY: ____ Initial dose followed by 2nd dose on day 15 (induction for RA)

____ Single dose ____ Every week for 4 weeks total ____ _____ (other)

PHYSICIAN NOTES: _____

ORDERING PROVIDER (Print Name): _____

Signature: _____ Date: _____

Phone: _____ Fax: _____

Birmingham ID & Infusion

4704 Cahaba River Road, Suite 101-D, Bham, AL 35243

Phone: (205) 739-2266 Fax: (205) 490-8663 Bhaminfusion.com

SIMPONI ARIA (Golimumab) Infusion Order

Patient Name (Print) _____ DOB _____

Phone _____ Patient Weight _____

*Please attach demographics, clinic notes & labs (Hep B, Qgold or Chest X-ray).

DIAGNOSIS (Please provide ICD-10 code):

_____ Rheumatoid Arthritis _____ Active Psoriatic Arthritis _____ _____ (other)

_____ Active Ankylosing Spondylitis

PRE-MEDICATION (IF NEEDED):

_____ Tylenol 1000mg PO _____ Solu-Cortef 100mg IVP _____ _____ (other)

_____ Pepcid 20mg PRN _____ Benadryl 25-50mg PRN

SIMPONI ARIA ORDERS/DOSAGE:

____ 2 mg/kg (weight based) ____ _____mg (flat dose)

FREQUENCY: ____ Every 4 and 8 weeks ____ Every ____weeks ____ _____ (other)

PHYSICIAN NOTES: _____

ORDERING PROVIDER (Print Name): _____

Signature: _____ Date: _____

Phone: _____ Fax: _____

Birmingham
ID & Infusion

4704 Cahaba River Road, Suite 101-D, Birmingham. AL 35243

Phone (205) 739-2266 Fax (205) 490-8663 Bhaminfusion.com

STELARA IV (Ustekinumab) Order

Patient Name _____ Male____ Female____

DOB _____ Phone _____ Patient Weight _____

* Please attach demographics, clinic notes & labs (Hep B, Qgold or Chest X-ray).

DIAGNOSIS (Please provide ICD-10 code): _____

_____ Crohn's Disease _____ _____ (other)

PRE-MEDICATION (IF NEEDED):

_____ Tylenol 1000mg PO _____ Solu-Cortef 100mg IVP _____ _____

_____ Pepcid 20mg IV PRN _____ Benadryl 50mg PRN

STELARA IV ORDERS/DOSAGE: ____ Up to 55kg-260mg (2 vials)

____Greater than 55kg to 85kg-390mg (3 vials) ____ Greater than 85kg-520mg (4 vials)
____ Initial Infusion followed by SQ injections ____ _____

PHYSICIAN NOTES: _____

ORDERING PROVIDER (Print Name): _____

Signature: _____ Date: _____

Phone: _____ Fax: _____

4704 Cahaba River Road, Suite 101-D, Birmingham. AL 35243

Phone (205) 739-2266 Fax (205) 490-8663 Bhaminfusion.com

STELARA SQ (Ustekinumab) Order

Patient Name _____ Male____ Female____

DOB _____ Phone _____ Patient Weight _____

* Please attach demographics, clinic notes & labs (Hep B, Qgold or Chest X-ray).

DIAGNOSIS (Please provide ICD-10 code): _____

_____ Crohn's Disease _____ _____ (other)

PRE-MEDICATION (IF NEEDED):

_____ Tylenol 1000mg PO _____ Solu-Cortef 100mg IVP _____ _____

_____ Pepcid 20mg IV PRN _____ Benadryl 50mg PRN

STELARA SQ ORDERS/DOSAGE: ____ 90mg Q 8 weeks

____ Initial Infusion followed by SQ injections ____ _____

PHYSICIAN NOTES: _____

ORDERING PROVIDER (Print Name): _____

Signature: _____ Date: _____

Phone: _____ Fax: _____

Birmingham ID & Infusion

4704 Cahaba River Road, Suite 101-D, Birmingham. AL 35243

Phone (205) 739-2266 Fax (205) 490-8663 Bhaminfusion.com

EVENITY (Romosozumab) Order

Patient Name _____ DOB _____

Phone _____ Patient Weight _____ Height _____

* Please attach demographics, clinic notes & labs (DEXA, calcium & vitamin D).

DIAGNOSIS (Please provide ICD-10 code):

_____ Age-related osteoporosis **without/with** (please circle) current pathological fracture

_____ _____ (other)

PRE-MEDICATION (IF NEEDED):

_____ Tylenol 1000mg PO _____ Solu-Cortef 100mg IVP _____ _____

_____ Pepcid 20mg IV PRN _____ Benadryl 50mg PRN

ORDERS/DOSAGE:

_____ _____

PHYSICIAN NOTES: _____

ORDERING PROVIDER (Print Name): _____

Signature: _____ Date: _____

Phone: _____ Fax: _____

4704 Cahaba River Road, Suite 101-D, Birmingham. AL 35243

Phone (205) 739-2266 Fax (205) 490-8663 Bhaminfusion.com

AVSOLA (Infliximab-Axxq) Order

Patient Name _____ DOB _____

Phone _____ Patient Weight _____ Height _____

*Please attach demographics, clinic notes & labs (Hep B, Qgold or chest X-ray).

DIAGNOSIS (Please provide ICD-10 code):

_____ Rheumatoid Arthritis _____ Psoriatic Arthritis _____ Plaque Psoriasis

_____ Ankylosing Spondylitis _____ Crohn's _____ Colitis _____ _____ (other)

PRE-MEDICATION (IF NEEDED):

_____ Tylenol 1000mg PO _____ Solu-Cortef 100mg IVP _____ _____

_____ Pepcid 20mg IV PRN _____ Benadryl 50mg PRN

ORDERS/DOSAGE:

_____ 100mg initial dose then every 2,6 & 8 weeks _____ _____(other)

PHYSICIAN NOTES: _____

ORDERING PROVIDER (Print Name): _____

Signature: _____ Date: _____

Phone: _____ Fax: _____

Birmingham ID & Infusion

4704 Cahaba River Road, Suite 101-D, Bham, AL 35243

Phone: (205) 739-2266 Fax: (205) 490-8663 Bhaminfusion.com

LEMTRADA (Alemtuzumab) Infusion Order

Patient Name (Print) _____ DOB _____

Phone _____ Patient Weight _____

*Please attach demographics, clinic notes & labs (Hep B, Qgold or Chest X-ray).

DIAGNOSIS (Please provide ICD-10 code): _____

____ Multiple Sclerosis

PRE-MEDICATION (IF NEEDED):

_____ Tylenol 1000mg PO _____ Solu-Cortef 100mg IVP _____ _____ (other)

_____ Pepcid 20mg PRN _____ Benadryl 25-50mg PRN

LEMTRADA ORDERS/DOSAGE:

_____ 12mg IV every day for 5 days _____ (other)

_____ 12mg IV every day for 3 days then 12 months after first treatment course

PHYSICIAN NOTES: _____

ORDERING PROVIDER (Print Name): _____

Signature: _____ Date: _____

Phone: _____ Fax: _____

4704 Cahaba River Road, Suite 101-D, Birmingham. AL 35243

Phone (205) 739-2266 Fax (205) 490-8663 Bhaminfusion.com

AVSOLA (Infliximab-Axxq) Order

Patient Name _____ DOB _____

Phone _____ Patient Weight _____ Height _____

*Please attach demographics, clinic notes & labs (Hep B, Qgold or chest X-ray).

DIAGNOSIS (Please provide ICD-10 code):

_____ Rheumatoid Arthritis _____ Psoriatic Arthritis _____ Plaque Psoriasis

_____ Ankylosing Spondylitis _____ Crohn's _____ Colitis _____ _____ (other)

PRE-MEDICATION (IF NEEDED):

_____ Tylenol 1000mg PO _____ Solu-Cortef 100mg IVP _____ _____

_____ Pepcid 20mg IV PRN _____ Benadryl 50mg PRN

ORDERS/DOSAGE:

_____ 100mg initial dose then every 2,6 & 8 weeks _____ _____(other)

PHYSICIAN NOTES: _____

ORDERING PROVIDER (Print Name): _____

Signature: _____ Date: _____

Phone: _____ Fax: _____

Birmingham
ID & Infusion

4704 Cahaba River Road, Suite 101-D, Bham, AL 35243

Phone: (205) 739-2266 Fax: (205) 490-8663 Bhaminfusion.com

RADICAVA (Edaravone) Infusion Order

Patient Name (Print) _____ DOB _____

Phone _____ Patient Weight _____

*Please attach demographics, clinic notes & labs (Hep B, Qgold or Chest X-ray).

DIAGNOSIS (Please provide ICD-10 code): _____

____ ALS

PRE-MEDICATION (IF NEEDED):

_____ Tylenol 1000mg PO _____ Solu-Cortef 100mg IVP _____ _____ (other)

_____ Pepcid 20mg PRN _____ Benadryl 25-50mg PRN

RADICAVA ORDERS/DOSAGE: _____ 60mg IV QD for 14 Days (Initial Dose)

PHYSICIAN NOTES: _____

ORDERING PROVIDER (Print Name): _____

Signature: _____ Date: _____

Phone: _____ Fax: _____

Birmingham
ID & Infusion

4704 Cahaba River Road, Suite 101-D, Birmingham. AL 35243

Phone (205) 739-2266 Fax (205) 490-8663 Bhaminfusion.com

Infusion Order for Medication (Print) _____

Patient Name _____ Male____ Female____

DOB _____ Phone _____ Patient Weight _____

* Please attach demographics, clinic notes & labs.

DIAGNOSIS (Please provide ICD-10 code): _____

_____ _____

PRE-MEDICATION (IF NEEDED):

_____ Tylenol 1000mg PO _____ Solu-Cortef 100mg IVP _____ _____

_____ Pepcid 20mg IV PRN _____ Benadryl 50mg PRN

ORDERS/DOSAGE:

____ _____

PHYSICIAN NOTES: _____

ORDERING PROVIDER (Print Name): _____

Signature: _____ Date: _____

Phone: _____ Fax: _____