



# BIOLOGICS ORDER FORM

**YOUR OSO REPRESENTATIVE:**

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Allergies: \_\_\_\_\_  
 Is patient pregnant?  Yes  No Patient's Height: \_\_\_\_\_ Patient's Weight (kg): \_\_\_\_\_  
 TB Test Performed?  Yes  No Date of negative TB Test: \_\_\_\_\_

### DIAGNOSIS INFORMATION:

Rheumatoid Arthritis. Diagnosis Code: \_\_\_\_\_  Other: \_\_\_\_\_ Diagnosis Code: \_\_\_\_\_

### PRE-MEDICATION:

Tylenol (Acetaminophen) 650 mg PO  Benadryl 25 mg PO  Zyrtec 10 mg PO  Other: \_\_\_\_\_  
 Benadryl 25 mg slow IVP  Solu-medrol slow IVP  20mg  40mg  100mg

### ACTEMRA (TOCLIZUMAB)

4 mg/kg IV every 4 weeks x 1 year. (Max 800 mg per dose).  
 8 mg/kg IV every 4 weeks x 1 year. (Max 800 mg per dose).  
 \_\_\_\_\_ mg/kg IV every \_\_\_\_\_ weeks x 1 year. Last Infusion Date: \_\_\_\_\_

### BENLYSTA (BELIMUMAB)

10 mg/kg IV every 2 weeks x 3 doses, then 10 mg/kg IV every 4 weeks x 1 year.  
 Induction dose complete. Continue 10 mg/kg IV every 4 weeks x 1 year.  
 \_\_\_\_\_ mg/kg IV every \_\_\_\_\_ weeks x 1 year. Last Infusion Date: \_\_\_\_\_

### CIMZIA

400 mg SQ on week 0, 2 and 4 then 200 mg every other week x 1 year.  
 Induction dose complete. Continue 200 mg SQ every other week x 1 year. Last Infusion Date: \_\_\_\_\_  
 \_\_\_\_\_ mg/kg IV every \_\_\_\_\_ weeks x 1 year. Last Infusion Date: \_\_\_\_\_

### COSENTYX (SECUKINUMAB)

6 mg/kg at week 0 as a loading dose, then 1.75 mg/kg (max 300 mg) IV every 4 weeks x 1 year.  
 Induction dose complete. Continue 1.75 mg/kg (max 300 mg) IV every 4 weeks x 1 year.  
 \_\_\_\_\_ mg/kg IV every \_\_\_\_\_ weeks x 1 year. Last Infusion Date: \_\_\_\_\_

### ORENCIA (ABATACEPT)

500 mg (< 60 kg)  750 mg (60-100 kg)  1000 mg (> 100 kg)  
 Infuse IV on weeks 0, 2, 4 then every 4 weeks x 1 year.  
 Induction dose complete. Continue IV every 4 weeks x 1 year. Last Infusion Date: \_\_\_\_\_

### REMICADE (INFLIXIMAB)

3 mg/kg IV on weeks 0, 2, 6, then every 8 weeks x 1 year.  
 Induction dose complete. Continue 3 mg/kg IV every 8 weeks x 1 year. Last Infusion Date: \_\_\_\_\_  
 \_\_\_\_\_ mg/kg IV every \_\_\_\_\_ weeks x 1 year. Last Infusion Date: \_\_\_\_\_

### INFLIXIMAB BIOSIMILAR

Inflectra  Avsola  Renflexis  Infliximab (Remicade generic)  
 3 mg/kg IV at weeks 0,2,6 and then every 8 weeks x 1 year  
 3 mg/kg continue IV every 8 weeks x 1 year. Last Infusion Date: \_\_\_\_\_  
 \_\_\_\_\_ mg/kg continue IV every \_\_\_\_\_ weeks x 1 year. Last infusion Date: \_\_\_\_\_

### RITUXAN (RITUXIMAB)

1000 mg IV on day 1 and day 15 every 24 weeks x 1 year.  
 1000 mg IV on day 1 and day 15 every \_\_\_\_\_ weeks x 1 year. (MUST BE AT LEAST 16 WEEKS APART).  
 375 mg/m<sup>2</sup> IV every 4 weeks (= \_\_\_\_\_ mg)

### SAPHNELO (ANIFROLUMAB-FNIA)

300 mg IV every 4 weeks x 1 year.  
 \_\_\_\_\_ mg/kg IV every \_\_\_\_\_ weeks x 1 year. Last Infusion Date: \_\_\_\_\_

### SIMPONI ARIA (GOLIMUMAB)

Simponi Aria 2 mg/kg IV at week 0, week 4, then every 8 weeks x 1 year  
 Simponi Aria 2 mg/kg continue IV every 8 weeks x 1 year. Last Infusion Date: \_\_\_\_\_  
 \_\_\_\_\_ mg/kg IV every \_\_\_\_\_ weeks x 1 year. Last Infusion Date: \_\_\_\_\_

### IN CASE OF REACTION

Follow Oso Protocol for anaphylaxis & infusion reactions.

### NURSING

Oso to coordinate nursing services in Ambulatory Infusion Suite.

### LAB ORDER:

CBD/diff  CMP  CRP  Vitamin D  Calcium  Quantiferon (TB) Test  
 Repeat every \_\_\_\_\_ months.

### PHYSICIAN INFORMATION

MD Name: \_\_\_\_\_ MD Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Office Contact: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_