Specialty Order Form

Oregon Specialty Infusion
A Practice of Oregon Specialty Group

Patient: ____________________	Ordering Provider: ____________________
DOB: __________ ☐ M ☐ 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

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

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:** ____________________

Fax completed form to **(503) 540-3105** *Questions? Call us at* **(503) 540-9999**