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

☐ **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: _____

☐ **Pre-medication(s):** _____

☐ **Labs/ Frequency:** _____

Physician's Signature: _____ **Date:** _____

Fax completed form to **(503) 540-3105**

Questions? Call us at **(503) 540-9999**

08/21