



Jupiter Infusion
 140 Jupiter Lakes Blvd, Suite A
 Jupiter, FL 33458
 Office: 561-277-9211

Rheumatology Order Form

PATIENT INFORMATION: Fax completed form, insurance information, and clinical documentation to 561-277-9226

Patient Name: _____ DOB: _____ Phone: _____

MEDICAL INFORMATION

Patient Weight: _____ lbs./kg. (required) Patient Height: _____ Allergies: _____

Diagnosis: _____

ICD-10 Code: _____

- | | |
|--|--|
| <input type="checkbox"/> Rheumatoid Arthritis, Unspecified | <input type="checkbox"/> Ankylosing Spondylitis, Unspecified |
| <input type="checkbox"/> Unspecified Iridocyclitis | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Arthropathic Psoriasis, Unspecified | <input type="checkbox"/> Wegener's granulomatosis |
| <input type="checkbox"/> Rheumatoid Arthritis w/ Rheumatoid Factor, Unspecified | <input type="checkbox"/> Systemic Lupus Erythematosus |
| <input type="checkbox"/> Rheumatoid Arthritis w/out Rheumatoid Factor, Unspecified | <input type="checkbox"/> Other: _____ |

THERAPY ORDER

Drug	Dosing	Refill
Actemra	<input type="checkbox"/> 4 mg/kg IV every 4 weeks for _____ doses, then 8mg/kg IV every 4 weeks <input type="checkbox"/> 4mg/kg IV every 4 weeks <input type="checkbox"/> 8mg/kg IV every 4 weeks <input type="checkbox"/> Other dose: _____ mg IV every _____ weeks	
Cimzia	<input type="checkbox"/> Initial Dose: 400mg SubQ at weeks 0, 2, and 4 <input type="checkbox"/> Maintenance Dose: <input type="checkbox"/> 200mg SubQ every 2 weeks OR <input type="checkbox"/> 400mg SubQ every 4 weeks	
Krystexxa	<input type="checkbox"/> 8mg IV every 2 weeks	
Immunoglobulin (Ig)	<input type="checkbox"/> IV <input type="checkbox"/> SubQ Brand: _____ Active Infusions to choose if not indicated <input type="checkbox"/> _____ gm/kg x _____ day(s) OR divided over _____ day(s) <input type="checkbox"/> _____ mg/kg x _____ day(s) OR divided over _____ day(s) Frequency: Every _____ weeks OR _____	
Orencia	Dose: _____ mg IV Frequency: <input type="checkbox"/> Every 4 weeks OR <input type="checkbox"/> 0, 2, 4 weeks and every 4 weeks thereafter	
Simponi Aria	<input type="checkbox"/> Initial Dose: 2mg/kg IV at weeks 0, 4, and then every 8 weeks <input type="checkbox"/> Maintenance Dose: 2mg/kg IV every 8 weeks	
Stelara	Initial Dose: <input type="checkbox"/> 45mg SubQ initially, at 4 weeks, then 45mg SubQ every 12 weeks <input type="checkbox"/> 90mg SubQ initially, at 4 weeks, then 90mg SubQ every 12 weeks Maintenance Dose: <input type="checkbox"/> 45mg SubQ every 12 weeks OR <input type="checkbox"/> 90mg SubQ every 12 weeks	
Infliximab	<input type="checkbox"/> May substitute biosimilar per insurance requirement <input type="checkbox"/> Do not substitute. Brand: _____ Dose: _____ mg/kg IV Frequency: <input type="checkbox"/> Every _____ weeks OR <input type="checkbox"/> 0, 2, 6, then every 8 weeks	
Rituximab	<input type="checkbox"/> May substitute biosimilar per insurance requirement <input type="checkbox"/> Do not substitute. Brand: _____ Dose: <input type="checkbox"/> 1000mg OR <input type="checkbox"/> 375mg/m ² OR <input type="checkbox"/> Other: _____ Frequency: <input type="checkbox"/> One-time dose OR <input type="checkbox"/> Weekly x 4 weeks OR <input type="checkbox"/> Day 0, repeat dose in 2 weeks	
Saphnelo	<input type="checkbox"/> 300mg IV every 4 weeks	
Premedication orders: Tylenol <input type="checkbox"/> 1000mg OR <input type="checkbox"/> 500 mg PO Please choose one antihistamine: <input type="checkbox"/> Diphenhydramine 25mg PO <input type="checkbox"/> Loratadine 10mg PO <input type="checkbox"/> Cetirizine 10mg PO <input type="checkbox"/> Other: _____ Additional premedications: <input type="checkbox"/> Solu-Medrol _____ mg IVP <input type="checkbox"/> Solu-Cortef _____ mg IVP <input type="checkbox"/> Other: _____		

Please provide patient's demographic information, insurance information, medication list, and clinical notes. JUPITER INFUSION will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and assist them in enrolling in any available co-pay assistance programs as needed/applicable. Thank you for the referral.

PROVIDER INFORMATION

Provider Name: _____ Signature: _____ Date: _____

Phone: _____ Fax: _____ Contact Person: _____