



Cascade ID & Infusion

Specialty Order Form

Patient: _____ DOB: _____ <input type="checkbox"/> M <input type="checkbox"/> F Height: _____ Weight: _____ lbs. Allergies: _____ Diagnosis: _____ ICD-10 Code(s): _____	Ordering Provider: _____ NPI: _____ Practice: _____ Phone: _____ Fax: _____ 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** 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** 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** 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

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

- BIOSIMILAR INFLIXIMAB:** **INFLECTRA** 100 mg vial **OR** **RENFLIXIS** 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 IV infusion as directed on:
- Day 1 & Day 15 (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:** _____