

RHEUMATOLOGY ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI _____ DOB: _____

HT: _____ in WT: _____ lbs kg Sex: Male Female Allergies: NKDA, _____

Physician Name _____ Contact Name _____ Contact Phone # _____

NPI #: _____ Tax ID#: _____ Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD-10 Code plus Description) _____

PERTINENT MEDICAL HISTORY

Does patient have venous access? YES NO If yes, what type MEDIPORT PIV PICC LINE OTHER: _____

1) TB test performed? Yes No Date: _____ Results: _____

2) Hep-B antigen surface antibody test? Yes No Date: _____

3) Patient previously treated with any of the following: (please select) Remicade Inflectra Simponi Aria Benlysta Rituxan Orencia Actemra Stelara, Date: _____

PRESCRIPTION ORDERS:

a) ALL MEDIPOINTS / IV ACCESSSES WILL BE FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL POLICY

b) ALL PRODUCTS WILL BE PREPARED AND ADMINISTERED FOLLOWING HOSPITAL POLICY

c) 500 mL BAG OF 0.9% NS MAY BE HUNG AT KVO RATE

IF LOADING DOSES HAVE BEEN INITIATED, LIST DOSE IN CYCLE TO BE GIVEN: _____

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY	DURATION
<input type="checkbox"/>	Actemra	_____ mg/kg	IV	Every _____ Weeks	
<input type="checkbox"/>	Benlysta Loading Dose(s)	10 mg / kg	IV	0, 2, 4 Weeks, Then Once Every 4 Weeks	
<input type="checkbox"/>	Benlysta Maintenance Dose	10 mg / kg	IV	Once Every 4 Weeks	
<input type="checkbox"/>	Krystexxa	8 mg	IV	Once Every 4 Weeks	
<input type="checkbox"/>	Orencia Loading Dose(s)	_____ mg	IV	0, 2, 4 Weeks, Then Once Every 4 Weeks	
<input type="checkbox"/>	Orencia Maintenance Dose(s)	500 mg	IV	Once Every 4 Weeks	
<input type="checkbox"/>	Orencia Maintenance Dose(s)	750 mg	IV	Once Every 4 Weeks	
<input type="checkbox"/>	Orencia Maintenance Dose(s)	1000 mg	IV	Once Every 4 Weeks	
<input type="checkbox"/>	Remicade Loading Dose(s)	_____ mg / kg	IV	0, 2, 6 Weeks, Then Once Every _____ Weeks	
<input type="checkbox"/>	Remicade Maintenance Dose(s)	_____ mg / kg	IV	Once Every _____ Weeks	
<input type="checkbox"/>	Rituxan	_____ mg / kg	IV	Once Every _____ Weeks	
<input type="checkbox"/>	Simponi Aria	_____ mg / kg	IV	Once Every _____ Weeks	
<input type="checkbox"/>	Stelara Loading Dose(s) <i>*SC administration is NOT covered Outpatient</i>	_____ mg	IV	Once	1

PREMEDS

SELECT	MEDICATION	DOSE	ROUTE
<input type="checkbox"/>	NONE	NA	NA
<input type="checkbox"/>	BENADRYL		
<input type="checkbox"/>	ACETAMINOPHEN		
<input type="checkbox"/>	OXYGEN		
<input type="checkbox"/>	SOLU-MEDROL		
<input type="checkbox"/>	ONDANSETRON		
<input type="checkbox"/>	FAMOTIDINE		
<input type="checkbox"/>	Other:		
<input type="checkbox"/>	Other:		
<input type="checkbox"/>	Other:		

LABS

SELECT	LAB REQUESTED	WHEN	FREQUENCY
<input type="checkbox"/>	NONE	NA	NA
<input type="checkbox"/>	BMP		
<input type="checkbox"/>	CMP		
<input type="checkbox"/>	BUN/CREATININE		
<input type="checkbox"/>	CRP		
<input type="checkbox"/>	ESR		
<input type="checkbox"/>	ALT		
<input type="checkbox"/>	AST		
<input type="checkbox"/>	LIVER PANEL		
<input type="checkbox"/>	OTHER:		

Physician's Signature _____ Time _____ Date _____

**Signature Must Be Legible*

Cosignature (If Required) _____ Time _____ Date _____

**Signature Must Be Legible*

Fax completed form, supporting documentation, faxesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.