

# Rheumatology Order Form

Fax completed form to: \_\_\_\_\_



PATIENT INFORMATION			
Patient Name:		Date of Birth:	Referral Date:
Address:		City/State/Zip:	
Home Phone:	Cell Phone:		Work Phone:
Secondary Contact:	Height:	Weight:	Male Female
Patient Diagnosis & ICD-10:			
Allergies:			
PROVIDER INFORMATION			
Physician Name:		Lic.#:	DEA #:
Practice Name:		NPI#:	
Address:		City/State/Zip:	
Office Contact:	Phone:		Fax:
Supervisory Physician (if applicable):			
PLEASE ATTACH			
Patient demographics & front/back copy of all insurance cards (prescription & medical) Recent office visit notes, history & physical, lab & pertinent procedure results Current medication list & list of prior medications tried and failed (with dates) HBV lab results within last 12 months ( <i>Infliximabs only, Orenia &amp; Actemra only</i> )		TB lab results within last 12 months ( <i>except for Prolia/Evenity</i> ) Absolute neutrophil count (ANC), platelet count, ALT and AST lab results ( <i>Actemra only</i> ) Letter of medical necessity if drug dosing or indication is outside of FDA guidelines	
NURSING & LAB ORDERS			
<b>Nurse Orders:</b> Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders. <b>Flush Orders:</b> NaCl 0.9% - 5-10mL flush pre and post infusion and as needed Heparin - 10units/mL ---OR--- 100units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line <b>Lab Orders:</b>			
PRESCRIPTION ORDERS			
<b>Anaphylaxis Kit:</b> Epinephrine 0.3mg IM as needed      Solu-cortef 250mg-500mg IV infusion as needed      Solu-Medrol 60mg - 125mg IV infusion as needed (Check all that apply) Diphenhydramine _____ mg IV infusion as needed      NS Hydration 500 ml IV infusion over 30 minutes as needed      Other _____ <b>Pre-Medications:</b> Acetaminophen _____ mg PO _____ minutes prior to infusion      Solu-Medrol _____ mg IV infusion _____ minutes prior to infusion (Check all that apply) Diphenhydramine _____ mg PO ---OR--- IV infusion _____ minutes prior to infusion      Other _____			
<b>Supply Orders:</b> All supplies for vascular access line care, drug administration kit(s), pump, and IV pole will be provided as necessary			
PRODUCT	PRESCRIPTION INFORMATION		REFILLS
Is this a first dose?    Yes    No    If No, when was last dose given? _____ When is patient due for next dose? _____			
ACTEMRA	<b>Induction:</b> 4mg/kg IV infusion via gravity- ---OR--- pump over at least 1 hour every ____ weeks <b>Maintenance:</b> IV infusion of 4mg/kg 6mg/kg 8mg/kg 10mg/kg 12mg/kg _____ mg/kg (max of 800mg) via gravity- ---OR--- pump over at least 1 hour Every week (patients >100kg or based on clinical response) 2 weeks (patients <100kg) Other: _____ Round up to nearest whole vial (must choose for Medicaid patients) Give exact dose		NONE
	<b>Evenity</b> 210mg SC injection monthly (recommended total of 12 doses)		_____
ILARIS	<b>For Still's Disease including Adult Onset Still's Disease and Systemic Juvenile Idiopathic Arthritis</b> 4mg/kg SC injection (max of 300mg) for patients ≥ 7.5kg every 4 weeks <b>For Cryopyrin-Associated Periodic Syndromes (CAPS)</b> 150mg SC injection for patients >40kg every 8 weeks 2mg/kg 3mg/kg SC injection for patients 15kg-40kg every 8 weeks		_____
INFLIXIMAB Avsola Inflectra Remicade Renflexis	<b>Induction:</b> 3mg/kg 5mg/kg 7.5mg/kg 10mg/kg or _____ mg IV infusion via gravity- ---OR--- pump over at least 2 hours at weeks 0, 2, and 6 <b>Maintenance:</b> 3mg/kg 5mg/kg 7.5mg/kg 10mg/kg _____ mg IV infusion via gravity ---OR--- pump over at least 2 hours every _____ weeks (Note: Round to nearest 100mg for Medicaid patients) If Remicade infusion tolerated, adjust infusion time according to manufacturer package insert.		NONE
	<b>Orenia</b> _____ mg IV infusion via gravity ---OR--- pump over at least 30 minutes at week 0, 2 and 4 <b>Maintenance:</b> _____ mg IV infusion via gravity ---OR--- pump over at least 30 minutes every _____ weeks 10kg to <25kg = 50mg SC injection weekly 25kg to <50kg 87.5 mg SC injection weekly 50kg or more 125mg SC injection weekly		_____
PROLIA	60mg SC injection every 6 months		_____
STELARA	<b>Psoriasis Adult Subcutaneous</b> For patients ≤ 100 kg, 45 mg SC injection initially and 4 weeks later, followed by 45 mg every 12 weeks For patients > 100 kg, 90 mg SC injection initially and 4 weeks later, followed by 90 mg every 12 weeks <b>Psoriatic Arthritis Adult</b> 45 mg SC injection initially and 4 weeks later, followed by 45 mg SC injection every 12 weeks For patients with co-existent moderate-to-severe plaque psoriasis weighing >100 kg, 90 mg SC injection initially and 4 weeks later, then every 12 weeks		_____
KRYSTEXXA	<b>For KRYSTEXXA, please refer to KRYSTEXXA Order Form</b> RITUXIMAB <b>For RITUXIMAB, please refer to RITUXIMAB Order Form</b>		_____
OTHER			_____
By signing this form and utilizing our services, you are authorizing Amerita to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.			

Prescriber's Signature  
Dispense as Written

Print Name

Date

Prescriber's Signature  
Substitution Permitted

Print Name

Date

