Rheumatology Order Form

Fax completed form to: (866) 330-7487

EVENTUS INFUSION

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 *(Infliximabs only, Orencia & Actemra only)*
- ☐ TB lab results within last 12 months *(except for Prolia/Evenity)*
- ☐ Absolute neutrophil count (ANC), platelet count, ALT and AST lab results *(Actemra only)*
- ☐ Letter of medical necessity if drug dosing or indication is outside of FDA guidelines

NURSING & LAB ORDERS

Nurse Orders: Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders.

Flush Orders: *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

Lab Orders: **Lab Date & Frequency:**

PRESCRIPTION ORDERS

Anaphylaxis Kit: (Check all that apply)
☐ Epinephrine 0.3mg IM as needed ☐ Solu-cortef 250mg-500mg IV infusion as needed ☐ Solu-Medrol 60mg - 125mg IV infusion as needed
☐ Diphenhydramine _____ mg IV infusion as needed ☐ NS Hydration 500 ml IV infusion over 30 minutes as needed ☐ Other

Pre-Medications: (Check all that apply)
☐ Acetaminophen _____mg PO _____ minutes prior to infusion ☐ Solu-Medrol _____mg IV infusion _____minutes prior to infusion
☐ Diphenhydramine _____ mg ☐ PO ***---OR---*** ☐ IV infusion _____minutes prior to infusion ☐ Other

Supply Orders: 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	☐ **Induction**: 4mg/kg IV infusion via ☐gravity- ***--OR---*** ☐pump over at least 1 hour every ____weeks	NONE
	☐ **Maintenance**: 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	_____
☐ EVENITY	210mg SC injection monthly (recommended total of 12 doses)	_____
☐ ILARIS	**For Stills Disease including Adult Onset Stills Disease and Systemic Juvenile Idiopathic Arthritis** ☐ 4mg/kg SC injection (max of 300mg) for patients ≥ 7.5kg every 4 weeks **For Cryopyrin-Associated Periodic Syndromes (CAPS)** ☐ 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	☐ **Induction**:☐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	NONE
	☐ **Maintenance**:☐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.	_____
☐ ORENCIA	☐ **Induction:** _____mg IV infusion via ☐gravity- ***--OR---*** ☐pump over at least 30 minutes at week 0,2 and 4	NONE
	☐ **Maintenance:** _____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	**Psoriasis Adult Subcutaneous** ☐ 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 **Psoriatic Arthritis Adult** ☐ 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	***For KRYSTEXXA, please refer to KRYSTEXXA Order Form*** ☐ RITUXIMAB ***For RITUXIMAB, please refer to RITUXIMAB Order Form***	
☐ OTHER		_____

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Prescriber's Signature **Print Name** **Date**
Dispense as Written

Prescriber's Signature **Print Name** **Date**
Substitution Permitted

EVR RHEU ORDER FORM 09-13-22

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