

# 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, Orencia &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>	<b>Lab Date &amp; Frequency:</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 _____	

**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	<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
EVENITY	210mg SC injection monthly (recommended total of 12 doses)	_____
ILARIS	<b>For Stills Disease including Adult Onset Stills 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 Inflixtra 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
ORENCIA	<b>Induction:</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	NONE
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 \_\_\_\_\_

