

Rheumatology Order Form

Fax Completed Form To:

Phone:

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)		☐ TB lab results within last 12 months (except for Prolia/Evenity)	
☐ Recent office visit notes, history & physical, lab & pertinent procedure results		☐ Absolute neutrophil count (ANC), platelet count, ALT and AST lab results (Actemra only)	
☐ Current medication list & list of prior medications tried and failed (with dates)		☐ Letter of medical necessity if drug dosing or indication is outside of FDA guidelines	
☐ HBV lab results within last 12 months (Infliximabs only, Orencia & Actemra only)			
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 (Tocilizumab) ☐ TYENNE (Tocilizumab-aazg) ☐ AVTOZMA (Tocilizumab-anoh)* *interchangeable biosimilar	☐ Induction: 4mg/kg IV infusion via ☐ gravity- ---OR--- ☐ pump over at least 1 hour every _____ weeks ☐ 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	NONE	
☐ COSENTYX	☐ Induction: 6mg/kg IV infusion over at least 30 minutes at week 0 Dosing Weight: _____ Dose: _____ ☐ Maintenance: 1.75mg/kg IV infusion over at least 30 minutes every _____ weeks Dosing Weight: _____ Dose: _____ ☐ Induction/Maintenance: _____mg SC at weeks 0, 1, 2, 3, and 4 followed by _____mg every _____ weeks	NONE	
☐ EVENITY	210mg SC injection monthly (recommended total of 12 doses)		
☐ ILARIS	For Still's Disease including Adult Onset Still's 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	
☐ INFILIXIMAB ☐ 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 ☐ 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.		NONE
☐ ORENCIA	☐ Induction: _____mg IV infusion via ☐ gravity- ---OR--- ☐ pump over at least 30 minutes at week 0, 2 and 4 ☐ 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		NONE
☐ PROLIA	60mg SC injection every 6 months		
☐ RITUXIMAB	☐ Induction: _____ ☐ Maintenance: _____		NONE
☐ KRYSTEXXA	For KRYSTEXXA, please refer to KRYSTEXXA Order Form		
☐ OTHER			

Prescriber's Signature
Dispense as Written

Print Name

Date

Prescriber's Signature
Substitution Permitted

Print Name

Date