US infusions
11500 State Hwy 121 Ste 910, Frisco, TX 75035
P: 469-200-2605 F: 469-200-2606 usinfusions.org

NEPHROLOGY ORDER SET

PATIENT INFORMATION:

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:** _____

DIAGNOSIS AND ICD-10 CODE:

☐ M32.9 - Systemic Lupus Erythematosus ☐ M32.14 – Lupus Nephritis ☐ Z94.0 – Kidney Transplant

PRESCRIPTION:

☐ **Benlysta:** ☐ Initial dose: 10mg/kg IV at 0, 14 days, 28 days, then every 28 days thereafter x1 year
☐ Maintenance dose: 10mg/kg IV every 28 days x1 year

☐ ***IVIG:** Dose: _____ mg/kg **OR** _____ gm/kg IV x _____ day(s) **OR** ☐ divided over _____ day(s)
Frequency: ☐ Every _____ weeks **OR** Other: _____ Refills: ☐ 1yr ☐ Other: _____

☐ ***Nulojix:** ☐ _____ mg IV every 4 weeks **OR** ☐ Other: _____

☐ ***Rituximab:** Dose: ☐ 1000mg ☐ 375mg/m² ☐ Other: _____
Frequency: ☐ One-time dose ☐ Weekly x4 weeks ☐ Day 0, repeat dose in 2 weeks ☐ Other: _____

☐ ***Gazyva:** Dose: ☐ 1000 mg IV **Schedule:** Week 0, 2, 24, 26, then every 6 months

THERAPIES TRIED AND FAILED, INTOLERANCES, OR CONTRAINDICATIONS TO CONVENTIONAL THERAPY:

_____

_____

REQUIRED PRE-SCREENING:

☐ Baseline creatinine w/attached results
Required for: IVIG

☐ Hepatitis B screening (antigen and core antibody total, not IgM) w/attached ☐ Positive ☐ Negative results
Required for: Rituximab, Gazyva

☐ Nulojix Distribution Program notification (855) 511-6180 – Patient ID#: _____

☐ TB screening test completed w/in 12mo w/attached ☐ Positive ☐ Negative results
Required for: Nulojix

☐ EBV serostatus
Required for: Nulojix

***if TB or HepB results are positive attach documentation of treatment or medical clearance, and a negative CXR (TB+)**

PROVIDER INFORMATION:

By signing this form, you authorize US Infusions and its staff to handle prior authorizations, coordinate with insurance providers, and determine the patient's preferred site of care.

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

****PLEASE COMPLETE BOTH SIDES OF THIS FORM****

US infusions
11500 State Hwy 121 Ste 910, Frisco, TX 75035
P: 469-200-2605 F: 469-200-2606 usinfusions.org

NEPHROLOGY ORDER SET

PATIENT INFORMATION:

Patient Name: _____ DOB: _____ Phone: _____

PREMEDICATION ORDERS:

☐ **Tylenol:** ☐ 500mg ☐ 1000mg by mouth

☐ **Antihistamine** (choose one): ☐ Cetirizine 10mg by mouth ☐ Diphenhydramine ☐ 25mg by mouth ☐ 50mg by mouth
☐ Loratadine 10mg by mouth

☐ **Solu-Medrol** ☐ 125mg IV **OR** ☐ Other: _____

REQUIRED ASSOCIATED DOCUMENTATION:

☐ Patient demographics ☐ Front/back of all insurance cards ☐ Current medication list ☐ Labs and/or test results

☐ Include clinical notes supporting the above diagnoses.

☐ Include clinical notes supporting contraindication/intolerance, or failed trial of conventional therapy or biologic.

☐ Trial and failure of Venofer if ordering Injectafer or Monoferric for Aetna, Cigna, Humana, or UHC insurances

☐ *If applicable* - Last know biological therapy: _____ and last date received: _____

☐ If switching to biologic therapy - please perform a wash-out period of _____ weeks prior to starting ordered biologic.

FAX COMPLETED FORM TO US INFUSIONS AT 469-200-2606