US infusions

NEPHROLOGY ORDER SET

NEPHROLOGY ORDERS:

Patient Name: _____ DOB: _____ Phone: _____
☐ New to therapy ☐ Continuing therapy: next treatment date: _____.

MEDICAL INFORMATION:

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

THERAPY ORDERS:

☐ **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/m^2 □ Other: _____
Frequency: □ One-time dose □ Weekly x4 weeks □ Day 0, repeat dose in 2 weeks □ Other: _____

***See opposite side for pre-medication orders**

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
☐ 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+)

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

US infusions

NEPHROLOGY ORDER SET

NEPHROLOGY ORDERS:

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 known biological therapy: _____ and last date received: _____.
☐ *If switching to biologic therapy* - please perform a wash-out period of _____ weeks before starting ordered biologic.

REFERRING PROVIDER INFORMATION:

Provider name: _____ Signature:_____ Date:_____

NPI: _____ Phone: _____ Fax: _____

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

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

11500 TX-121 STE 910 FRISCO, TX 75035 P:469-200-2605 F:469-200-2606