LIVbetter INFUSIONS

PEDIATRIC REFERRAL & ORDER

Xolair *omalizumab*

P: 331-236-0610 | F: 331-314-8989 Fax with insurance cards + clinical notes

FDA-labeled ages: Asthma 6+ · IgE-mediated food allergy 1+ · Chronic spontaneous urticaria 12+ **Route:** Subcutaneous, in office

PATIENT

PATIENT NAME	DATE OF BIRTH	AGE	SEX

WEIGHT (kg) — REQUIRED	DATE WEIGHED	ALLERGIES	STATUS
			☐ New ☐ Continuing

PARENT / GUARDIAN NAME	RELATIONSHIP	BEST PHONE	LANGUAGE

REFERRING PRESCRIBER & INSURANCE

PRESCRIBER NAME	NPI #	PHONE	FAX

PRIMARY INSURANCE	POLICY #	GROUP #	NEXT TREATMENT DATE

DIAGNOSIS ICD-10 required — check all that apply

ASTHMA

☐ J45.40 Moderate persistent, uncomplicated
☐ J45.50 Severe persistent, uncomplicated
☐ J45.41 / J45.51 With (status) exacerbation

FOOD ALLERGY

☐ Z91.018 Allergy to other foods
☐ T78.00XA Anaphylactic reaction to food

URTICARIA

☐ L50.1 Idiopathic / chronic spontaneous urticaria

SUPPORTING

☐ J30.1 / J30.2 Allergic rhinitis
☐ L20.9 Atopic dermatitis
☐ Other: _____

OTHER ICD-10	PRIMARY DIAGNOSIS DESCRIPTION

DOSE asthma and food allergy doses are assigned from the FDA table using PRE-TREATMENT IgE and weight

STEP 1 — REQUIRED TO ASSIGN A DOSE we cannot calculate the dose without both of these

Pre-treatment total serum IgE	Result: _____ IU/mL Date drawn: _____ Must be drawn BEFORE the first dose. A level drawn during treatment cannot be used.
Body weight	_____ kg Date weighed: _____

STEP 2 — INDICATION

Asthma age 6 and older	☐ Dose from FDA Table 1 (12+) or Table 2 (6 to <12) — 75 mg to 375 mg SC ☐ every 2 weeks ☐ every 4 weeks ☐ LIVbetter to assign from the table
Food allergy age 1 and older	☐ Dose from FDA Table 4 — 75 mg to 600 mg SC ☐ every 2 weeks ☐ every 4 weeks ☐ LIVbetter to assign from the table Continue strict food-allergen avoidance. Not for emergency treatment of an allergic reaction.
Chronic urticaria age 12 and older	☐ 150 mg SC every 4 weeks ☐ 300 mg SC every 4 weeks Urticaria dosing is NOT based on IgE or weight.

BOXED WARNING Anaphylaxis has occurred after the first dose and after a year of treatment. Observe after every injection and confirm an epinephrine auto-injector is prescribed.

WHAT WE NEED TO START a missing item here is the most common reason a referral stalls

Every pediatric referral	☐ Signed and completed order ☐ Current weight, measured within 30 days ☐ Patient demographics and insurance ☐ Current medication list ☐ Clinical notes (H&P) supporting the diagnosis ☐ Immunization record ☐ Tried and failed therapy: _____
Xolair	☐ Pre-treatment total serum IgE with date ☐ Weight ☐ Epinephrine auto-injector prescribed and in hand ☐ Asthma — positive skin test or in vitro reactivity to a perennial aeroallergen ☐ Asthma — inadequate control on inhaled corticosteroids ☐ Food allergy — specific IgE or skin test result, and the foods: _____

PRESCRIBER SIGNATURE required — we cannot schedule without it

By signing, you authorize LIVbetter Infusions to act as your prior authorization and specialty pharmacy designated agent with insurance companies and to select the site of care.

PRESCRIBER SIGNATURE	DATE	DISPENSE AS WRITTEN
X		☐ Yes

LIVbetter INFUSIONS

PEDIATRIC REFERRAL & ORDER

Nucala *mepolizumab*

P: 331-236-0610 | F: 331-314-8989 Fax with insurance cards + clinical notes

FDA-labeled ages: Severe eosinophilic asthma 6+ · Hypereosinophilic syndrome 12+ · EGPA and nasal polyps 18+ **Route:** Subcutaneous, in office

PATIENT

PATIENT NAME	DATE OF BIRTH	AGE	SEX

WEIGHT (kg) — REQUIRED	DATE WEIGHED	ALLERGIES	STATUS
			☐ New ☐ Continuing

PARENT / GUARDIAN NAME	RELATIONSHIP	BEST PHONE	LANGUAGE

REFERRING PRESCRIBER & INSURANCE

PRESCRIBER NAME	NPI #	PHONE	FAX

PRIMARY INSURANCE	POLICY #	GROUP #	NEXT TREATMENT DATE

DIAGNOSIS ICD-10 required — check all that apply

ASTHMA
☐ J45.50 Severe persistent, uncomplicated
☐ J45.51 / J45.52 With exacerbation / status

EOSINOPHILIC
☐ D72.10 Eosinophilia, unspecified
☐ D72.110 Idiopathic hypereosinophilic syndrome

OTHER
☐ M30.1 Eosinophilic granulomatosis with polyangiitis
☐ J33.9 Nasal polyp, unspecified
☐ Other: _____

SUPPORTING
☐ Oral corticosteroid dependent — current dose: _____ mg/day

OTHER ICD-10	PRIMARY DIAGNOSIS DESCRIPTION

DOSE check the band that matches this patient · refills × 1 year unless noted

SEVERE EOSINOPHILIC ASTHMA	
Age 6 to 11	☐ 40 mg SC every 4 weeks 40 mg regardless of body weight (40 mg/0.4 mL syringe).
Age 12 and older	☐ 100 mg SC every 4 weeks
HYPEREOSINOPHILIC SYNDROME	
Age 12 and older	☐ 300 mg SC every 4 weeks — given as three 100 mg injections, at least 5 cm apart
EGPA / NASAL POLYPS adults only — safety and effectiveness under 18 not established	
Age 18 and older	☐ EGPA: 300 mg SC every 4 weeks (three 100 mg injections) ☐ CRSwNP: 100 mg SC every 4 weeks

WHAT WE NEED TO START a missing item here is the most common reason a referral stalls

Every pediatric referral	☐ Signed and completed order ☐ Current weight, measured within 30 days ☐ Patient demographics and insurance ☐ Current medication list ☐ Clinical notes (H&P) supporting the diagnosis ☐ Immunization record ☐ Tried and failed therapy: _____
Nucala	☐ Blood eosinophil count with date: _____ cells/mcL ☐ Pre-existing helminth (parasitic) infection treated before starting ☐ Varicella / zoster vaccination status reviewed ☐ Asthma — exacerbations in the past 12 months: _____ ☐ on high-dose ICS + a second controller

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PRESCRIBER SIGNATURE	DATE	DISPENSE AS WRITTEN
X		☐ Yes

LIVbetter INFUSIONS

PEDIATRIC REFERRAL & ORDER

Fasenra *benralizumab*

P: 331-236-0610 | F: 331-314-8989 Fax with insurance cards + clinical notes

FDA-labeled ages: Severe eosinophilic asthma 6+ · Hypereosinophilic syndrome 12+ · EGPA 18+ **Route:** Subcutaneous, in office

PATIENT

PATIENT NAME	DATE OF BIRTH	AGE	SEX

WEIGHT (kg) — REQUIRED	DATE WEIGHED	ALLERGIES	STATUS
			☐ New ☐ Continuing

PARENT / GUARDIAN NAME	RELATIONSHIP	BEST PHONE	LANGUAGE

REFERRING PRESCRIBER & INSURANCE

PRESCRIBER NAME	NPI #	PHONE	FAX

PRIMARY INSURANCE	POLICY #	GROUP #	NEXT TREATMENT DATE

DIAGNOSIS ICD-10 required — check all that apply

ASTHMA

☐ J45.50 Severe persistent, uncomplicated

☐ J45.51 / J45.52 With exacerbation / status

EOSINOPHILIC

☐ D72.10 Eosinophilia, unspecified

☐ D72.110 Idiopathic hypereosinophilic syndrome

OTHER

☐ M30.1 Eosinophilic granulomatosis with polyangiitis (18+)

☐ Other: _____

SUPPORTING

☐ Oral corticosteroid dependent — current dose: _____ mg/day

OTHER ICD-10	PRIMARY DIAGNOSIS DESCRIPTION

DOSE check the band that matches this patient · refills × 1 year unless noted

SEVERE EOSINOPHILIC ASTHMA first 3 doses every 4 weeks, then every 8 weeks

Age 6 to 11 under 35 kg	☐ 10 mg SC every 4 weeks × 3 doses, then 10 mg SC every 8 weeks
Age 6 to 11 35 kg or more	☐ 30 mg SC every 4 weeks × 3 doses, then 30 mg SC every 8 weeks
Age 12 and older	☐ 30 mg SC every 4 weeks × 3 doses, then 30 mg SC every 8 weeks

HYPEREOSINOPHILIC SYNDROME / EGPA every 4 weeks — no loading schedule

HES, age 12+	☐ 30 mg SC every 4 weeks
EGPA, age 18+	☐ 30 mg SC every 4 weeks

WHAT WE NEED TO START a missing item here is the most common reason a referral stalls

Every pediatric referral	☐ Signed and completed order ☐ Current weight, measured within 30 days ☐ Patient demographics and insurance ☐ Current medication list ☐ Clinical notes (H&P) supporting the diagnosis ☐ Immunization record ☐ Tried and failed therapy: _____
Fasenra	☐ Blood eosinophil count with date: _____ cells/mcL ☐ Pre-existing helminth (parasitic) infection treated before starting ☐ Asthma — exacerbations in the past 12 months: _____ ☐ on high-dose ICS + a second controller

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PRESCRIBER SIGNATURE	DATE	DISPENSE AS WRITTEN
X		☐ Yes

LIVbetter INFUSIONS

PEDIATRIC REFERRAL & ORDER

Dupixent *dupilumab*

P: 331-236-0610 | F: 331-314-8989 Fax with insurance cards + clinical notes

FDA-labeled ages: Atopic dermatitis 6 months+ · Asthma 6+ · EoE 1+ and ≥15 kg · Chronic spontaneous urticaria 2+ **Route:** Subcutaneous, in office

PATIENT

PATIENT NAME	DATE OF BIRTH	AGE	SEX

WEIGHT (kg) — REQUIRED	DATE WEIGHED	ALLERGIES	STATUS
			☐ New ☐ Continuing

PARENT / GUARDIAN NAME	RELATIONSHIP	BEST PHONE	LANGUAGE

REFERRING PRESCRIBER & INSURANCE

PRESCRIBER NAME	NPI #	PHONE	FAX

PRIMARY INSURANCE	POLICY #	GROUP #	NEXT TREATMENT DATE

DIAGNOSIS ICD-10 required — check all that apply

ATOPIC DERMATITIS
☐ L20.81 / L20.82 / L20.84 / L20.89 Atopic dermatitis

ASTHMA
☐ J45.40 / J45.50 Moderate / severe persistent

EOSINOPHILIC ESOPHAGITIS
☐ K20.0 Eosinophilic esophagitis

URTICARIA
☐ L50.1 Chronic spontaneous urticaria
☐ Other: _____

OTHER ICD-10	PRIMARY DIAGNOSIS DESCRIPTION

DOSE pick the indication, then the weight band · loading dose is given as two injections at separate sites

ATOPIC DERMATITIS / CHRONIC SPONTANEOUS URTICARIA AD from 6 months · CSU from 2 years	
Age 6 mo to 5 yr 5 to <15 kg	☐ No loading dose — 200 mg SC every 4 weeks
Age 6 mo to 5 yr 15 to <30 kg	☐ No loading dose — 300 mg SC every 4 weeks
Age 6 to 17 15 to <30 kg	☐ Load 600 mg (two 300 mg), then 300 mg SC every 4 weeks
Age 6 to 17 30 to <60 kg	☐ Load 400 mg (two 200 mg), then 200 mg SC every 2 weeks
Age 6 to 17 60 kg or more	☐ Load 600 mg (two 300 mg), then 300 mg SC every 2 weeks
ASTHMA	
Age 6 to 11 15 to <30 kg	☐ No loading dose — 300 mg SC every 4 weeks
Age 6 to 11 30 kg or more	☐ No loading dose — 200 mg SC every 2 weeks
Age 12 to 17	☐ Load 400 mg, then 200 mg SC every 2 weeks (patients ≥60 kg) ☐ Load 600 mg, then 300 mg SC every 2 weeks Oral-steroid-dependent asthma, or co-existing moderate-to-severe atopic dermatitis: load 600 mg, then 300 mg every 2 weeks.
EOSINOPHILIC ESOPHAGITIS age 1 and older, at least 15 kg · no loading dose	
15 to <30 kg	☐ 200 mg SC every 2 weeks
30 to <40 kg	☐ 300 mg SC every 2 weeks
40 kg or more	☐ 300 mg SC every week

WHAT WE NEED TO START a missing item here is the most common reason a referral stalls

Every pediatric referral	☐ Signed and completed order ☐ Current weight, measured within 30 days ☐ Patient demographics and insurance ☐ Current medication list ☐ Clinical notes (H&P) supporting the diagnosis ☐ Immunization record ☐ Tried and failed therapy: _____
Dupixent	☐ Weight and date ☐ Baseline eosinophil count if asthma or EoE ☐ Helminth (parasitic) infection treated before starting ☐ Ophthalmology note if conjunctivitis or keratitis history ☐ Under 12 — doses must be given by a caregiver or in office

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PRESCRIBER SIGNATURE	DATE	DISPENSE AS WRITTEN
X		☐ Yes

LIVbetter INFUSIONS

PEDIATRIC REFERRAL & ORDER

Tezspire *tezepelumab-ekko*

P: 331-236-0610 | F: 331-314-8989 Fax with insurance cards + clinical notes

FDA-labeled ages: Severe asthma, add-on maintenance — 12 and older (under 12 not established) **Route:** Subcutaneous, in office

PATIENT

PATIENT NAME	DATE OF BIRTH	AGE	SEX

WEIGHT (kg) — REQUIRED	DATE WEIGHED	ALLERGIES	STATUS
			☐ New ☐ Continuing

PARENT / GUARDIAN NAME	RELATIONSHIP	BEST PHONE	LANGUAGE

REFERRING PRESCRIBER & INSURANCE

PRESCRIBER NAME	NPI #	PHONE	FAX

PRIMARY INSURANCE	POLICY #	GROUP #	NEXT TREATMENT DATE

DIAGNOSIS ICD-10 required — check all that apply

ASTHMA

☐ J45.50 Severe persistent, uncomplicated
☐ J45.51 With (acute) exacerbation
☐ J45.52 With status asthmaticus
☐ J45.40 Moderate persistent, uncomplicated

SUPPORTING

☐ J30.1 / J30.2 Allergic rhinitis
☐ J33.9 Nasal polyp
☐ Oral corticosteroid dependent — current dose: _____ mg/day
☐ Other: _____

OTHER ICD-10	PRIMARY DIAGNOSIS DESCRIPTION

DOSE check the band that matches this patient · refills × 1 year unless noted

Age 12 and older	☐ 210 mg SC every 4 weeks No loading dose. No weight adjustment. No eosinophil threshold — Tezspire is not restricted to an eosinophilic phenotype.
Under age 12	Not established — do not order. Call us to discuss alternatives.

WHAT WE NEED TO START a missing item here is the most common reason a referral stalls

Every pediatric referral	☐ Signed and completed order ☐ Current weight, measured within 30 days ☐ Patient demographics and insurance ☐ Current medication list ☐ Clinical notes (H&P) supporting the diagnosis ☐ Immunization record ☐ Tried and failed therapy: _____
Tezspire	☐ Exacerbations in the past 12 months: _____ ☐ on medium-to-high dose ICS + a second controller ☐ Pre-existing helminth (parasitic) infection treated before starting ☐ Not for acute bronchospasm or status asthmaticus — rescue plan in place

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PRESCRIBER SIGNATURE	DATE	DISPENSE AS WRITTEN
X		☐ Yes

LIVbetter INFUSIONS

PEDIATRIC REFERRAL & ORDER

Actemra *tocilizumab*

P: 331-236-0610 | F: 331-314-8989 Fax with insurance cards + clinical notes

FDA-labeled ages: Polyarticular JIA 2+ · Systemic JIA 2+ **Route:** IV infusion over 60 minutes, or subcutaneous

PATIENT

PATIENT NAME	DATE OF BIRTH	AGE	SEX

WEIGHT (kg) — REQUIRED	DATE WEIGHED	ALLERGIES	STATUS
			☐ New ☐ Continuing

PARENT / GUARDIAN NAME	RELATIONSHIP	BEST PHONE	LANGUAGE

REFERRING PRESCRIBER & INSURANCE

PRESCRIBER NAME	NPI #	PHONE	FAX

PRIMARY INSURANCE	POLICY #	GROUP #	NEXT TREATMENT DATE

DIAGNOSIS ICD-10 required — check all that apply

JUVENILE ARTHRITIS

☐ M08.00 Juvenile rheumatoid arthritis, unspecified
☐ M08.2 Juvenile arthritis with systemic onset
☐ M08.3 Juvenile rheumatoid polyarthritis (seroneg.)
☐ M08.4 Pauciarticular juvenile rheumatoid arthritis

OTHER

☐ M06.9 Rheumatoid arthritis, unspecified
☐ Other: _____

CONCOMITANT

☐ Methotrexate — dose: _____ mg weekly
☐ No concomitant methotrexate

OTHER ICD-10	PRIMARY DIAGNOSIS DESCRIPTION

DOSE the 30 kg cutoff drives every band · do not change the dose on a single weight reading

POLYARTICULAR JIA age 2 and older	
IV — under 30 kg	☐ 10 mg/kg IV every 4 weeks
IV — 30 kg or more	☐ 8 mg/kg IV every 4 weeks
SC — under 30 kg	☐ 162 mg SC every 3 weeks
SC — 30 kg or more	☐ 162 mg SC every 2 weeks
SYSTEMIC JIA age 2 and older	
IV — under 30 kg	☐ 12 mg/kg IV every 2 weeks
IV — 30 kg or more	☐ 8 mg/kg IV every 2 weeks
SC — under 30 kg	☐ 162 mg SC every 2 weeks
SC — 30 kg or more	☐ 162 mg SC every week

BOXED WARNING Serious infections leading to hospitalization or death, including tuberculosis, bacterial, invasive fungal, viral and other opportunistic infections.

WHAT WE NEED TO START a missing item here is the most common reason a referral stalls

Every pediatric referral	☐ Signed and completed order ☐ Current weight, measured within 30 days ☐ Patient demographics and insurance ☐ Current medication list ☐ Clinical notes (H&P) supporting the diagnosis ☐ Immunization record ☐ Tried and failed therapy: _____
Actemra	☐ TB screening — IGRA or PPD, with date and result: _____ ☐ Hepatitis B surface antigen and core antibody ☐ Baseline CBC with differential ☐ Baseline ALT / AST ☐ Baseline lipid panel ☐ Live vaccines completed before starting — none while on therapy ☐ Not to be started during an active infection

PRE-MEDICATIONS & LABS

Pre-meds	☐ Acetaminophen 15 mg/kg PO (max 650 mg) ☐ Diphenhydramine 1 mg/kg ☐ PO ☐ IV (max 50 mg) ☐ Methylprednisolone _____ mg IV ☐ Other: _____ ☐ None
Labs	Orders: _____ Frequency: _____ Drawn by: ☐ LIVbetter ☐ Referring provider

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PRESCRIBER SIGNATURE	DATE	DISPENSE AS WRITTEN
X		☐ Yes

LIVbetter INFUSIONS

PEDIATRIC REFERRAL & ORDER

Orencia *abatacept*

P: 331-236-0610 | F: 331-314-8989 Fax with insurance cards + clinical notes

FDA-labeled ages: Polyarticular JIA — IV 6+, SC 2+ · Pediatric psoriatic arthritis — SC 2+ **Route:** IV infusion over 30 minutes, or subcutaneous weekly

PATIENT

PATIENT NAME	DATE OF BIRTH	AGE	SEX

WEIGHT (kg) — REQUIRED	DATE WEIGHED	ALLERGIES	STATUS
			☐ New ☐ Continuing

PARENT / GUARDIAN NAME	RELATIONSHIP	BEST PHONE	LANGUAGE

REFERRING PRESCRIBER & INSURANCE

PRESCRIBER NAME	NPI #	PHONE	FAX

PRIMARY INSURANCE	POLICY #	GROUP #	NEXT TREATMENT DATE

DIAGNOSIS ICD-10 required — check all that apply

JUVENILE ARTHRITIS

☐ M08.00 Juvenile rheumatoid arthritis, unspecified
☐ M08.3 Juvenile rheumatoid polyarthritis (seronegative)
☐ M08.4 Pauciarticular juvenile rheumatoid arthritis

PSORIATIC

☐ L40.54 Psoriatic juvenile arthropathy
☐ L40.50 Arthropathic psoriasis, unspecified
☐ Other: _____

OTHER ICD-10	PRIMARY DIAGNOSIS DESCRIPTION

DOSE check the band that matches this patient · refills × 1 year unless noted

INTRAVENOUS — POLYARTICULAR JIA age 6 and older · infusions at week 0, 2 and 4, then every 4 weeks	
Under 75 kg	☐ 10 mg/kg IV at weeks 0, 2 and 4, then every 4 weeks
75 to 100 kg	☐ 750 mg IV at weeks 0, 2 and 4, then every 4 weeks
Over 100 kg	☐ 1,000 mg IV at weeks 0, 2 and 4, then every 4 weeks (maximum dose)
SUBCUTANEOUS — pJIA AND PEDIATRIC PsA age 2 and older · once weekly · no IV loading dose	
10 to <25 kg	☐ 50 mg SC once weekly
25 to <50 kg	☐ 87.5 mg SC once weekly
50 kg or more	☐ 125 mg SC once weekly

WHAT WE NEED TO START a missing item here is the most common reason a referral stalls

Every pediatric referral	☐ Signed and completed order ☐ Current weight, measured within 30 days ☐ Patient demographics and insurance ☐ Current medication list ☐ Clinical notes (H&P) supporting the diagnosis ☐ Immunization record ☐ Tried and failed therapy: _____
Orencia	☐ TB screening — IGRA or PPD, with date and result: _____ ☐ Hepatitis B screening ☐ Live vaccines completed before starting ☐ COPD history noted — higher rate of respiratory adverse events ☐ Not to be given with TNF blockers or other biologic DMARDs

PRE-MEDICATIONS & LABS

Pre-meds	☐ Acetaminophen 15 mg/kg PO (max 650 mg) ☐ Diphenhydramine 1 mg/kg ☐ PO ☐ IV (max 50 mg) ☐ Methylprednisolone _____ mg IV ☐ Other: _____ ☐ None
Labs	Orders: _____ Frequency: _____ Drawn by: ☐ LIVbetter ☐ Referring provider

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PRESCRIBER SIGNATURE	DATE	DISPENSE AS WRITTEN
X		☐ Yes

LIVbetter INFUSIONS

PEDIATRIC REFERRAL & ORDER

Remicade *infliximab*

P: 331-236-0610 | F: 331-314-8989 Fax with insurance cards + clinical notes

FDA-labeled ages: Pediatric Crohn's disease 6+ · Pediatric ulcerative colitis 6+ **Route:** IV infusion over at least 2 hours

PATIENT

PATIENT NAME	DATE OF BIRTH	AGE	SEX

WEIGHT (kg) — REQUIRED	DATE WEIGHED	ALLERGIES	STATUS
			☐ New ☐ Continuing

PARENT / GUARDIAN NAME	RELATIONSHIP	BEST PHONE	LANGUAGE

REFERRING PRESCRIBER & INSURANCE

PRESCRIBER NAME	NPI #	PHONE	FAX

PRIMARY INSURANCE	POLICY #	GROUP #	NEXT TREATMENT DATE

DIAGNOSIS ICD-10 required — check all that apply

CROHN'S DISEASE

☐ K50.00 Crohn's of small intestine w/o complications
☐ K50.10 Crohn's of large intestine w/o complications
☐ K50.80 Crohn's of both w/o complications
☐ K50.013 / K50.113 With fistula

ULCERATIVE COLITIS

☐ K51.00 Ulcerative (chronic) pancolitis w/o complications
☐ K51.20 Ulcerative (chronic) proctitis
☐ K51.90 Ulcerative colitis, unspecified
☐ Other: _____

OTHER ICD-10	PRIMARY DIAGNOSIS DESCRIPTION

DOSE same regimen for both pediatric indications · biosimilars may be substituted per payer

PEDIATRIC CROHN'S DISEASE AND ULCERATIVE COLITIS age 6 and older

Induction	☐ 5 mg/kg IV at week 0, week 2 and week 6
Maintenance	☐ 5 mg/kg IV every 8 weeks
Dose adjustment if ordered	☐ Increase to _____ mg/kg IV every _____ weeks ☐ Shorten interval to every _____ weeks Adults may escalate to 10 mg/kg. Pediatric escalation is prescriber-directed — state the dose and interval above.
Under age 6	Not established — do not order.

BOXED WARNING Serious infections including TB, invasive fungal and other opportunistic infections. Lymphoma and other malignancies, including hepatosplenic T-cell lymphoma — reported mostly in adolescent and young adult males with IBD on infliximab plus azathioprine or 6-MP.

WHAT WE NEED TO START a missing item here is the most common reason a referral stalls

Every pediatric referral	☐ Signed and completed order ☐ Current weight, measured within 30 days ☐ Patient demographics and insurance ☐ Current medication list ☐ Clinical notes (H&P) supporting the diagnosis ☐ Immunization record ☐ Tried and failed therapy: _____
Remicade	☐ TB screening — IGRA or PPD, with date and result: _____ ☐ Hepatitis B surface antigen and core antibody ☐ Baseline CBC and CMP ☐ Live vaccines completed before starting — none while on therapy ☐ Concomitant azathioprine / 6-MP? ☐ yes ☐ no — see the boxed warning above ☐ Heart failure history reviewed ☐ Not to be started during an active infection

PRE-MEDICATIONS & LABS

Pre-meds	☐ Acetaminophen 15 mg/kg PO (max 650 mg) ☐ Diphenhydramine 1 mg/kg ☐ PO ☐ IV (max 50 mg) ☐ Methylprednisolone _____ mg IV ☐ Other: _____ ☐ None
Labs	Orders: _____ Frequency: _____ Drawn by: ☐ LIVbetter ☐ Referring provider

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PRESCRIBER SIGNATURE	DATE	DISPENSE AS WRITTEN
X		☐ Yes

LIVbetter INFUSIONS

PEDIATRIC REFERRAL & ORDER

Simponi Aria *golimumab, intravenous*

P: 331-236-0610 | F: 331-314-8989 Fax with insurance cards + clinical notes

FDA-labeled ages: Polyarticular JIA 2+ · Pediatric psoriatic arthritis 2+ **Route:** IV infusion over 30 minutes

PATIENT

PATIENT NAME	DATE OF BIRTH	AGE	SEX

WEIGHT (kg) — REQUIRED	HEIGHT (cm) — REQUIRED	BSA (m²) IF KNOWN	DATE MEASURED	STATUS
				☐ New ☐ Cont.

PARENT / GUARDIAN NAME	RELATIONSHIP	BEST PHONE	LANGUAGE

REFERRING PRESCRIBER & INSURANCE

PRESCRIBER NAME	NPI #	PHONE	FAX

PRIMARY INSURANCE	POLICY #	GROUP #	NEXT TREATMENT DATE

DIAGNOSIS ICD-10 required — check all that apply

JUVENILE ARTHRITIS

☐ M08.00 Juvenile rheumatoid arthritis, unspecified
☐ M08.3 Juvenile rheumatoid polyarthritis (seronegative)
☐ M08.4 Pauciarticular juvenile rheumatoid arthritis

PSORIATIC

☐ L40.54 Psoriatic juvenile arthropathy
☐ L40.50 Arthropathic psoriasis, unspecified
☐ Other: _____

OTHER ICD-10	PRIMARY DIAGNOSIS DESCRIPTION

DOSE pediatric dosing is by body surface area — height AND weight are both required

PEDIATRIC pJIA AND PsA age 2 and older

All pediatric patients	☐ 80 mg/m² IV over 30 minutes at week 0 and week 4, then every 8 weeks Calculated dose: _____ mg BSA used: _____ m² We will recalculate the BSA at each visit from the measured height and weight.

ADULT DOSING for reference if the patient transitions

Age 18 and older	☐ 2 mg/kg IV at week 0 and week 4, then every 8 weeks (RA: with methotrexate)

BOXED WARNING Serious infections leading to hospitalization or death, including TB, invasive fungal and other opportunistic infections. Lymphoma and other malignancies have been reported in children and adolescents on TNF blockers.

WHAT WE NEED TO START a missing item here is the most common reason a referral stalls

Every pediatric referral	☐ Signed and completed order ☐ Current weight, measured within 30 days ☐ Patient demographics and insurance ☐ Current medication list ☐ Clinical notes (H&P) supporting the diagnosis ☐ Immunization record ☐ Tried and failed therapy: _____
Simponi Aria	☐ Height AND weight — both required to calculate the dose ☐ TB screening — IGRA or PPD, with date and result: _____ ☐ Hepatitis B surface antigen and core antibody ☐ Live vaccines completed before starting — none while on therapy ☐ Heart failure history reviewed ☐ Not to be started during an active infection

PRE-MEDICATIONS & LABS

Pre-meds	☐ Acetaminophen 15 mg/kg PO (max 650 mg) ☐ Diphenhydramine 1 mg/kg ☐ PO ☐ IV (max 50 mg) ☐ Methylprednisolone _____ mg IV ☐ Other: _____ ☐ None
Labs	Orders: _____ Frequency: _____ Drawn by: ☐ LIVbetter ☐ Referring provider

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PRESCRIBER SIGNATURE	DATE	DISPENSE AS WRITTEN
X		☐ Yes

LIVbetter INFUSIONS

PEDIATRIC REFERRAL & ORDER

Benlysta *belimumab*

P: 331-236-0610 | F: 331-314-8989 Fax with insurance cards + clinical notes

FDA-labeled ages: Active SLE 5+ · Active lupus nephritis 5+ (SC requires at least 15 kg) **Route:** IV infusion over 1 hour, or subcutaneous autoinjector

PATIENT

PATIENT NAME	DATE OF BIRTH	AGE	SEX

WEIGHT (kg) — REQUIRED	DATE WEIGHED	ALLERGIES	STATUS
			☐ New ☐ Continuing

PARENT / GUARDIAN NAME	RELATIONSHIP	BEST PHONE	LANGUAGE

REFERRING PRESCRIBER & INSURANCE

PRESCRIBER NAME	NPI #	PHONE	FAX

PRIMARY INSURANCE	POLICY #	GROUP #	NEXT TREATMENT DATE

DIAGNOSIS ICD-10 required — check all that apply

LUPUS

☐ M32.9 SLE, unspecified
☐ M32.10 SLE, organ or system involvement unspecified
☐ M32.14 Glomerular disease in SLE (lupus nephritis)
☐ M32.8 Other forms of SLE

SUPPORTING

☐ N04.9 Nephrotic syndrome
☐ D69.51 Posttransfusion purpura
☐ Other: _____

ON STANDARD THERAPY

☐ Yes — current regimen: _____

OTHER ICD-10	PRIMARY DIAGNOSIS DESCRIPTION

DOSE check the band that matches this patient · refills × 1 year unless noted

INTRAVENOUS age 5 and older · SLE and lupus nephritis use the same IV regimen	
All patients	☐ 10 mg/kg IV over 1 hour at weeks 0, 2 and 4, then every 4 weeks
SUBCUTANEOUS — SLE age 5 and older, at least 15 kg · autoinjector only in children	
40 kg or more	☐ 200 mg SC once weekly
15 to <40 kg	☐ 200 mg SC once every 2 weeks
SUBCUTANEOUS — LUPUS NEPHRITIS age 5 and older, at least 15 kg	
40 kg or more	☐ 400 mg SC weekly × 4 doses (two 200 mg injections), then 200 mg SC weekly
15 to <40 kg	☐ 200 mg SC weekly × 4 doses, then 200 mg SC every 2 weeks

WHAT WE NEED TO START a missing item here is the most common reason a referral stalls

Every pediatric referral	☐ Signed and completed order ☐ Current weight, measured within 30 days ☐ Patient demographics and insurance ☐ Current medication list ☐ Clinical notes (H&P) supporting the diagnosis ☐ Immunization record ☐ Tried and failed therapy: _____
Benlysta	☐ No live vaccines in the 30 days before the first dose, or during treatment ☐ Baseline infection screen ☐ Current immunosuppressant regimen listed ☐ Depression, suicidality and mood reviewed with the family — monitor and report new symptoms ☐ Not recommended with other biologics or IV cyclophosphamide ☐ Not studied in severe active CNS lupus

PRE-MEDICATIONS & LABS

Pre-meds	☐ Acetaminophen 15 mg/kg PO (max 650 mg) ☐ Diphenhydramine 1 mg/kg ☐ PO ☐ IV (max 50 mg) ☐ Methylprednisolone _____ mg IV ☐ Other: _____ ☐ None
Labs	Orders: _____ Frequency: _____ Drawn by: ☐ LIVbetter ☐ Referring provider

PRESCRIBER SIGNATURE required — we cannot schedule without it

By signing, you authorize LIVbetter Infusions to act as your prior authorization and specialty pharmacy designated agent with insurance companies and to select the site of care.

PRESCRIBER SIGNATURE	DATE	DISPENSE AS WRITTEN
X		☐ Yes

LIVbetter INFUSIONS

PEDIATRIC REFERRAL & ORDER

Rituxan *rituximab*

P: 331-236-0610 | F: 331-314-8989 Fax with insurance cards + clinical notes

FDA-labeled ages: Pediatric GPA and MPA · Pediatric mature B-cell NHL / B-AL from 6 months **Route:** IV infusion

PATIENT

PATIENT NAME	DATE OF BIRTH	AGE	SEX

WEIGHT (kg) — REQUIRED	HEIGHT (cm) — REQUIRED	BSA (m²) IF KNOWN	DATE MEASURED	STATUS
				☐ New ☐ Cont.

PARENT / GUARDIAN NAME	RELATIONSHIP	BEST PHONE	LANGUAGE

REFERRING PRESCRIBER & INSURANCE

PRESCRIBER NAME	NPI #	PHONE	FAX

PRIMARY INSURANCE	POLICY #	GROUP #	NEXT TREATMENT DATE

DIAGNOSIS ICD-10 required — check all that apply

VASCULITIS

☐ M31.30 Wegener's granulomatosis w/o renal involvement
☐ M31.31 Wegener's granulomatosis with renal involvement
☐ M31.7 Microscopic polyangiitis

OTHER

☐ C83.- Mature B-cell non-Hodgkin lymphoma
☐ Other: _____

OTHER ICD-10	PRIMARY DIAGNOSIS DESCRIPTION

DOSE dosing is by body surface area — height AND weight are both required

PEDIATRIC GPA / MPA — INDUCTION

Induction	☐ 375 mg/m² IV once weekly × 4 weeks ☐ Methylprednisolone 30 mg/kg IV daily × 3 days (max 1 g/day) before the first infusion Oral glucocorticoids continue per the prescriber's protocol.

PEDIATRIC GPA / MPA — FOLLOW-UP after disease control is achieved

Follow-up	☐ 250 mg/m² IV × 2 infusions, 2 weeks apart, then 250 mg/m² IV every 6 months If induction used a rituximab product, begin follow-up within 24 weeks of the last induction infusion and no sooner than 16 weeks.
Calculated	Dose: _____ mg BSA used: _____ m² Regimen: _____

BOXED WARNING Fatal infusion-related reactions. Severe mucocutaneous reactions. Hepatitis B virus reactivation, in some cases fatal. Progressive multifocal leukoencephalopathy (PML).

WHAT WE NEED TO START a missing item here is the most common reason a referral stalls

Every pediatric referral	☐ Signed and completed order ☐ Current weight, measured within 30 days ☐ Patient demographics and insurance ☐ Current medication list ☐ Clinical notes (H&P) supporting the diagnosis ☐ Immunization record ☐ Tried and failed therapy: _____
Rituxan	☐ Height AND weight — both required to calculate the dose ☐ HBsAg AND anti-HBc — required in ALL patients before the first dose ☐ Baseline CBC with differential ☐ Quantitative immunoglobulins ☐ PJP prophylaxis ordered — during treatment and for at least 6 months after the last infusion ☐ Live vaccines completed before starting
Required pre-meds	☐ Methylprednisolone 100 mg IV or equivalent, 30 minutes before each infusion ☐ Acetaminophen + antihistamine 30 to 60 minutes before each infusion

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PRESCRIBER SIGNATURE	DATE	DISPENSE AS WRITTEN
X		☐ Yes

LIVbetter INFUSIONS

PEDIATRIC REFERRAL & ORDER

Ilaris *canakinumab*

P: 331-236-0610 | F: 331-314-8989 Fax with insurance cards + clinical notes

FDA-labeled ages: Still's disease incl. systemic JIA 2+ (≥7.5 kg) · CAPS 4+ · TRAPS, HIDS/MKD and FMF — adult and pediatric **Route:** Subcutaneous, in office

PATIENT

PATIENT NAME	DATE OF BIRTH	AGE	SEX

WEIGHT (kg) — REQUIRED	DATE WEIGHED	ALLERGIES	STATUS
			☐ New ☐ Continuing

PARENT / GUARDIAN NAME	RELATIONSHIP	BEST PHONE	LANGUAGE

REFERRING PRESCRIBER & INSURANCE

PRESCRIBER NAME	NPI #	PHONE	FAX

PRIMARY INSURANCE	POLICY #	GROUP #	NEXT TREATMENT DATE

DIAGNOSIS ICD-10 required — check all that apply

STILL'S DISEASE

☐ M08.2 Juvenile arthritis with systemic onset (sJIA)
☐ M06.1 Adult-onset Still's disease

CAPS

☐ M04.2 Cryopyrin-associated periodic syndromes

PERIODIC FEVER SYNDROMES

☐ M04.1 Periodic fever syndromes (TRAPS, HIDS/MKD)
☐ M04.1 Familial Mediterranean fever
☐ Other: _____

GENETIC CONFIRMATION

☐ Attached — gene: _____

OTHER ICD-10	PRIMARY DIAGNOSIS DESCRIPTION

DOSE check the band that matches this patient · refills × 1 year unless noted

STILL'S DISEASE (systemic JIA and adult-onset) age 2 and older, at least 7.5 kg	
7.5 kg or more	☐ 4 mg/kg SC every 4 weeks — maximum 300 mg per dose
CAPS (FCAS, Muckle-Wells) age 4 and older	
Over 40 kg	☐ 150 mg SC every 8 weeks
15 to 40 kg	☐ 2 mg/kg SC every 8 weeks ☐ Inadequate response — increase to 3 mg/kg SC every 8 weeks
TRAPS / HIDS-MKD / FMF	
Over 40 kg	☐ 150 mg SC every 4 weeks ☐ Inadequate response — increase to 300 mg every 4 weeks
40 kg or less	☐ 2 mg/kg SC every 4 weeks ☐ Inadequate response — increase to 4 mg/kg every 4 weeks

WHAT WE NEED TO START a missing item here is the most common reason a referral stalls

Every pediatric referral	☐ Signed and completed order ☐ Current weight, measured within 30 days ☐ Patient demographics and insurance ☐ Current medication list ☐ Clinical notes (H&P) supporting the diagnosis ☐ Immunization record ☐ Tried and failed therapy: _____
Ilaris	☐ TB screening — IGRA or PPD, with date and result: _____ ☐ Baseline CBC with differential — neutrophil count: _____ ☐ Live vaccines completed before starting — none while on therapy ☐ Not to be given with a TNF blocker or anakinra ☐ Not to be started during an active infection

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PRESCRIBER SIGNATURE	DATE	DISPENSE AS WRITTEN
X		☐ Yes

LIVbetter INFUSIONS

PEDIATRIC REFERRAL & ORDER

Stelara *ustekinumab*

P: 331-236-0610 | F: 331-314-8989 Fax with insurance cards + clinical notes

FDA-labeled ages: Plaque psoriasis 6+ · Psoriatic arthritis 6+ · Crohn's disease 2+ (≥10 kg) · UC adults only **Route:** IV induction (Crohn's), then subcutaneous

PATIENT

PATIENT NAME	DATE OF BIRTH	AGE	SEX

WEIGHT (kg) — REQUIRED	DATE WEIGHED	ALLERGIES	STATUS
			☐ New ☐ Continuing

PARENT / GUARDIAN NAME	RELATIONSHIP	BEST PHONE	LANGUAGE

REFERRING PRESCRIBER & INSURANCE

PRESCRIBER NAME	NPI #	PHONE	FAX

PRIMARY INSURANCE	POLICY #	GROUP #	NEXT TREATMENT DATE

DIAGNOSIS ICD-10 required — check all that apply

PSORIASIS
☐ L40.0 Psoriasis vulgaris
☐ L40.8 Other psoriasis

PSORIATIC ARTHRITIS
☐ L40.50 Arthropathic psoriasis, unspecified
☐ L40.54 Psoriatic juvenile arthropathy

CROHN'S DISEASE
☐ K50.00 Crohn's of small intestine w/o complications
☐ K50.10 Crohn's of large intestine w/o complications
☐ K50.80 Crohn's of both w/o complications
☐ Other: _____

OTHER ICD-10	PRIMARY DIAGNOSIS DESCRIPTION

DOSE check the band that matches this patient · refills × 1 year unless noted

PLAQUE PSORIASIS — SUBCUTANEOUS age 6 and older · weeks 0 and 4, then every 12 weeks	
Under 60 kg	☐ 0.75 mg/kg SC — calculated dose: _____ mg
60 to 100 kg	☐ 45 mg SC
Over 100 kg	☐ 90 mg SC
PSORIATIC ARTHRITIS — SUBCUTANEOUS age 6 and older · weeks 0 and 4, then every 12 weeks	
Under 60 kg	☐ 0.75 mg/kg SC — calculated dose: _____ mg
60 kg or more	☐ 45 mg SC ☐ 90 mg SC — if co-existing moderate-to-severe plaque psoriasis
PEDIATRIC CROHN'S DISEASE age 2 and older, at least 10 kg · one IV induction, then SC every 8 weeks	
IV induction single infusion	☐ 10 to 25 kg: 10 mg/kg IV ☐ >25 to 55 kg: 260 mg IV ☐ >55 to 85 kg: 390 mg IV ☐ >85 kg: 520 mg IV
SC maintenance from week 8	☐ 10 to 35 kg: 2.5 mg/kg SC every 8 weeks ☐ Over 35 kg: 90 mg SC every 8 weeks First SC dose is given 8 weeks after the IV induction infusion.

WHAT WE NEED TO START a missing item here is the most common reason a referral stalls

Every pediatric referral	☐ Signed and completed order ☐ Current weight, measured within 30 days ☐ Patient demographics and insurance ☐ Current medication list ☐ Clinical notes (H&P) supporting the diagnosis ☐ Immunization record ☐ Tried and failed therapy: _____
Stelara	☐ TB screening — IGRA or PPD, with date and result: _____ ☐ Live vaccines (BCG, MMR, varicella) completed before starting — none while on therapy ☐ Baseline CBC ☐ Not to be started during an active infection ☐ Confirm whether the payer requires a specific biosimilar

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PRESCRIBER SIGNATURE	DATE	DISPENSE AS WRITTEN
X		☐ Yes

Doses shown are from current FDA labeling. Weight is required on every pediatric referral — we cannot schedule without it.

LIVbetter INFUSIONS

PEDIATRIC REFERRAL & ORDER

Humira *adalimumab*

P: 331-236-0610 | F: 331-314-8989 Fax with insurance cards + clinical notes

FDA-labeled ages: JIA and uveitis 2+ (≥10 kg) · UC 5+ · Crohn's 6+ · Hidradenitis suppurativa 12+ (≥30 kg) **Route:** Subcutaneous

PATIENT

PATIENT NAME	DATE OF BIRTH	AGE	SEX

WEIGHT (kg) — REQUIRED	DATE WEIGHED	ALLERGIES	STATUS
			☐ New ☐ Continuing

PARENT / GUARDIAN NAME	RELATIONSHIP	BEST PHONE	LANGUAGE

REFERRING PRESCRIBER & INSURANCE

PRESCRIBER NAME	NPI #	PHONE	FAX

PRIMARY INSURANCE	POLICY #	GROUP #	NEXT TREATMENT DATE

DIAGNOSIS ICD-10 required — check all that apply

ARTHRITIS & UVEITIS
☐ M08.00 Juvenile rheumatoid arthritis, unspecified
☐ H20.00 / H20.10 Iridocyclitis (pediatric uveitis)

HIDRADENITIS
☐ L73.2 Hidradenitis suppurativa

CROHN'S DISEASE
☐ K50.00 / K50.10 / K50.80 Crohn's disease

ULCERATIVE COLITIS
☐ K51.00 Ulcerative (chronic) pancolitis
☐ K51.90 Ulcerative colitis, unspecified
☐ Other: _____

OTHER ICD-10	PRIMARY DIAGNOSIS DESCRIPTION

DOSE Day 1 and Day 8/15 doses are the initial doses · maintenance begins where shown · EOW = every other week

JUVENILE IDIOPATHIC ARTHRITIS AND PEDIATRIC UVEITIS age 2 and older · no loading dose	
10 to <15 kg	☐ 10 mg SC every other week
15 to <30 kg	☐ 20 mg SC every other week
30 kg or more	☐ 40 mg SC every other week
PEDIATRIC CROHN'S DISEASE age 6 and older	
17 to <40 kg	☐ Day 1: 80 mg → Day 15: 40 mg → from Day 29: 20 mg SC every other week
40 kg or more	☐ Day 1: 160 mg → Day 15: 80 mg → from Day 29: 40 mg SC every other week
PEDIATRIC ULCERATIVE COLITIS age 5 and older	
20 to <40 kg	☐ Day 1: 80 mg → Day 8: 40 mg → Day 15: 40 mg → from Day 29: ☐ 40 mg EOW ☐ 20 mg weekly
40 kg or more	☐ Day 1: 160 mg → Day 8: 80 mg → Day 15: 80 mg → from Day 29: ☐ 80 mg EOW ☐ 40 mg weekly
HIDRADENITIS SUPPURATIVA age 12 and older, at least 30 kg	
30 to <60 kg	☐ Day 1: 80 mg → from Day 8: 40 mg SC every other week
60 kg or more	☐ Day 1: 160 mg → Day 15: 80 mg → from Day 29: ☐ 40 mg weekly ☐ 80 mg EOW

BOXED WARNING Serious infections including TB, invasive fungal and other opportunistic infections. Lymphoma and other malignancies, including hepatosplenic T-cell lymphoma, have been reported in children and adolescents on TNF blockers.

WHAT WE NEED TO START a missing item here is the most common reason a referral stalls

Every pediatric referral	☐ Signed and completed order ☐ Current weight, measured within 30 days ☐ Patient demographics and insurance ☐ Current medication list ☐ Clinical notes (H&P) supporting the diagnosis ☐ Immunization record ☐ Tried and failed therapy: _____
Humira	☐ TB screening — IGRA or PPD, with date and result: _____ ☐ Hepatitis B surface antigen and core antibody ☐ Live vaccines completed before starting — none while on therapy ☐ Not to be started during an active infection ☐ Confirm the payer's preferred biosimilar

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PRESCRIBER SIGNATURE	DATE	DISPENSE AS WRITTEN
X		☐ Yes

LIVbetter INFUSIONS

PEDIATRIC REFERRAL & ORDER

Cosentyx *secukinumab*

P: 331-236-0610 | F: 331-314-8989 Fax with insurance cards + clinical notes

FDA-labeled ages: Pediatric plaque psoriasis 6+ (other indications adults only) **Route:** Subcutaneous

PATIENT

PATIENT NAME	DATE OF BIRTH	AGE	SEX

WEIGHT (kg) — REQUIRED	DATE WEIGHED	ALLERGIES	STATUS
			☐ New ☐ Continuing

PARENT / GUARDIAN NAME	RELATIONSHIP	BEST PHONE	LANGUAGE

REFERRING PRESCRIBER & INSURANCE

PRESCRIBER NAME	NPI #	PHONE	FAX

PRIMARY INSURANCE	POLICY #	GROUP #	NEXT TREATMENT DATE

DIAGNOSIS ICD-10 required — check all that apply

PSORIASIS

☐ L40.0 Psoriasis vulgaris
☐ L40.8 Other psoriasis
☐ L40.1 Generalized pustular psoriasis

SUPPORTING

☐ Body surface area involved: _____ %
☐ Candidate for systemic therapy or phototherapy
☐ Other: _____

OTHER ICD-10	PRIMARY DIAGNOSIS DESCRIPTION

DOSE check the band that matches this patient · refills × 1 year unless noted

PEDIATRIC PLAQUE PSORIASIS age 6 and older · loading at weeks 0, 1, 2, 3 and 4, then every 4 weeks

Under 50 kg	☐ 75 mg SC at weeks 0, 1, 2, 3 and 4, then 75 mg SC every 4 weeks
50 kg or more	☐ 150 mg SC at weeks 0, 1, 2, 3 and 4, then 150 mg SC every 4 weeks
Other pediatric indications	Not established — psoriatic arthritis, ankylosing spondylitis and nr-axSpA are adult indications.

WHAT WE NEED TO START a missing item here is the most common reason a referral stalls

Every pediatric referral	☐ Signed and completed order ☐ Current weight, measured within 30 days ☐ Patient demographics and insurance ☐ Current medication list ☐ Clinical notes (H&P) supporting the diagnosis ☐ Immunization record ☐ Tried and failed therapy: _____
Cosentyx	☐ TB screening — IGRA or PPD, with date and result: _____ ☐ Inflammatory bowel disease history — Crohn's and UC can worsen; monitor if present ☐ Live vaccines completed before starting ☐ Latex allergy noted — the removable cap on some presentations contains natural rubber latex

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PRESCRIBER SIGNATURE	DATE	DISPENSE AS WRITTEN
X		☐ Yes

Doses shown are from current FDA labeling. Weight is required on every pediatric referral — we cannot schedule without it.

LIVbetter INFUSIONS

PEDIATRIC REFERRAL & ORDER

Taltz *ixekizumab*

P: 331-236-0610 | F: 331-314-8989 Fax with insurance cards + clinical notes

FDA-labeled ages: Pediatric plaque psoriasis 6+ (other indications adults only) **Route:** Subcutaneous

PATIENT

PATIENT NAME	DATE OF BIRTH	AGE	SEX

WEIGHT (kg) — REQUIRED	DATE WEIGHED	ALLERGIES	STATUS
			☐ New ☐ Continuing

PARENT / GUARDIAN NAME	RELATIONSHIP	BEST PHONE	LANGUAGE

REFERRING PRESCRIBER & INSURANCE

PRESCRIBER NAME	NPI #	PHONE	FAX

PRIMARY INSURANCE	POLICY #	GROUP #	NEXT TREATMENT DATE

DIAGNOSIS ICD-10 required — check all that apply

PSORIASIS

☐ L40.0 Psoriasis vulgaris
☐ L40.8 Other psoriasis

SUPPORTING

☐ Body surface area involved: _____ %
☐ Candidate for systemic therapy or phototherapy
☐ Other: _____

OTHER ICD-10	PRIMARY DIAGNOSIS DESCRIPTION

DOSE check the band that matches this patient · refills × 1 year unless noted

PEDIATRIC PLAQUE PSORIASIS age 6 and older · one starting dose at week 0, then every 4 weeks

Over 50 kg	☐ 160 mg SC at week 0, then 80 mg SC every 4 weeks
25 to 50 kg	☐ 80 mg SC at week 0, then 40 mg SC every 4 weeks
Under 25 kg	☐ 40 mg SC at week 0, then 20 mg SC every 4 weeks 20 mg and 40 mg doses must be prepared by a healthcare professional if the matching syringe is unavailable.

WHAT WE NEED TO START a missing item here is the most common reason a referral stalls

Every pediatric referral	☐ Signed and completed order ☐ Current weight, measured within 30 days ☐ Patient demographics and insurance ☐ Current medication list ☐ Clinical notes (H&P) supporting the diagnosis ☐ Immunization record ☐ Tried and failed therapy: _____
Taltz	☐ TB screening — IGRA or PPD, with date and result: _____ ☐ Inflammatory bowel disease history — Crohn's and UC can worsen; monitor if present ☐ Live vaccines completed before starting ☐ Latex allergy noted — the needle shield on some presentations contains natural rubber latex

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PRESCRIBER SIGNATURE	DATE	DISPENSE AS WRITTEN
X		☐ Yes

LIVbetter INFUSIONS

PEDIATRIC REFERRAL & ORDER

IVIg *immune globulin, intravenous*

P: 331-236-0610 | F: 331-314-8989 Fax with insurance cards + clinical notes

FDA-labeled ages: Primary immunodeficiency, ITP and Kawasaki disease — age floor varies by brand **Route:** IV infusion

PATIENT

PATIENT NAME	DATE OF BIRTH	AGE	SEX

WEIGHT (kg) — REQUIRED	DATE WEIGHED	ALLERGIES	STATUS
			☐ New ☐ Continuing

PARENT / GUARDIAN NAME	RELATIONSHIP	BEST PHONE	LANGUAGE

REFERRING PRESCRIBER & INSURANCE

PRESCRIBER NAME	NPI #	PHONE	FAX

PRIMARY INSURANCE	POLICY #	GROUP #	NEXT TREATMENT DATE

DIAGNOSIS ICD-10 required — check all that apply

IMMUNODEFICIENCY

☐ D80.1 Nonfamilial hypogammaglobulinemia
☐ D83.9 Common variable immunodeficiency
☐ D80.0 Hereditary hypogammaglobulinemia
☐ D81.9 Combined immunodeficiency

OTHER

☐ D69.3 Immune thrombocytopenic purpura
☐ M30.3 Kawasaki disease
☐ G61.81 CIDP
☐ G61.0 Guillain-Barré syndrome
☐ Other: _____

OTHER ICD-10	PRIMARY DIAGNOSIS DESCRIPTION

DOSE the labeled dose range and the minimum age both depend on the BRAND — tell us if a brand is required

PRIMARY IMMUNODEFICIENCY

All ages per brand

☐ 300 to 800 mg/kg IV every 3 to 4 weeks — ordered dose: _____ mg/kg every _____ weeks

Labeled range and age floor vary by brand (e.g. Privigen 200–800 mg/kg; Flebogamma and Gammagard S/D 300–600 mg/kg from age 2). Target trough IgG ≥600 mg/dL.

IMMUNE THROMBOCYTOPENIC PURPURA

ITP

☐ 1 g/kg IV daily × 2 consecutive days ☐ 400 mg/kg IV daily × 2 to 5 consecutive days
☐ Single 400 mg/kg infusion for maintenance ☐ Other: _____

KAWASAKI DISEASE start within 7 days of fever onset

Kawasaki

☐ 1 g/kg IV × 1 dose ☐ 400 mg/kg IV daily × 4 consecutive days
☐ Concomitant aspirin 80 to 100 mg/kg/day in 4 divided doses

BRAND AND RATE

Product

Brand: _____ ☐ LIVbetter to choose ☐ Do not substitute

BOXED WARNING Thrombosis. Renal dysfunction and acute renal failure, which may be fatal — risk is highest with sucrose-containing products. Infuse at the lowest practicable rate.

WHAT WE NEED TO START a missing item here is the most common reason a referral stalls

Every pediatric referral

☐ Signed and completed order ☐ Current weight, measured within 30 days
☐ Patient demographics and insurance ☐ Current medication list
☐ Clinical notes (H&P) supporting the diagnosis ☐ Immunization record
☐ Tried and failed therapy: _____

IVIg

☐ Baseline quantitative IgG (and IgA if known) ☐ Baseline creatinine
☐ Documentation of recurrent infections, if immunodeficiency
☐ Vaccine response testing, if immunodeficiency ☐ Weight
☐ Thrombosis risk factors noted ☐ IgA deficiency status — risk of anaphylaxis
☐ Live vaccines may be ineffective for several months after IVIg — schedule noted

PRE-MEDICATIONS & LABS

Pre-meds

☐ Acetaminophen 15 mg/kg PO (max 650 mg) ☐ Diphenhydramine 1 mg/kg ☐ PO ☐ IV (max 50 mg)
☐ Methylprednisolone _____ mg IV ☐ Other: _____ ☐ None

Labs

Orders: _____ Frequency: _____ Drawn by: ☐ LIVbetter ☐ Referring provider

PRESCRIBER SIGNATURE required — we cannot schedule without it

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PRESCRIBER SIGNATURE	DATE	DISPENSE AS WRITTEN
X		☐ Yes

LIVbetter INFUSIONS

PEDIATRIC REFERRAL & ORDER

Soliris *eculizumab*

P: 331-236-0610 | F: 331-314-8989 Fax with insurance cards + clinical notes

FDA-labeled ages: aHUS — pediatric · Generalized myasthenia gravis 6+ · PNH and NMOSD 18+ **Route:** IV infusion

PATIENT

PATIENT NAME	DATE OF BIRTH	AGE	SEX

WEIGHT (kg) — REQUIRED	DATE WEIGHED	ALLERGIES	STATUS
			☐ New ☐ Continuing

PARENT / GUARDIAN NAME	RELATIONSHIP	BEST PHONE	LANGUAGE

REFERRING PRESCRIBER & INSURANCE

PRESCRIBER NAME	NPI #	PHONE	FAX

PRIMARY INSURANCE	POLICY #	GROUP #	NEXT TREATMENT DATE

DIAGNOSIS ICD-10 required — check all that apply

COMPLEMENT-MEDIATED

☐ D59.31 Infection-associated hemolytic-uremic syndrome
☐ D59.32 Hereditary hemolytic-uremic syndrome
☐ D59.39 Other hemolytic-uremic syndrome
☐ D59.5 Paroxysmal nocturnal hemoglobinuria (18+)

NEUROMUSCULAR

☐ G70.00 Myasthenia gravis without exacerbation
☐ G70.01 Myasthenia gravis with exacerbation
☐ G36.0 NMOSD (18+)
☐ Other: _____

OTHER ICD-10	PRIMARY DIAGNOSIS DESCRIPTION

DOSE weight bands below are the pediatric aHUS and gMG regimens · supplemental dosing is required after plasma exchange

PEDIATRIC WEIGHT BANDS aHUS (under 18) and generalized myasthenia gravis (6 and older)	
5 to <10 kg	☐ 300 mg IV at week 1 → 300 mg at week 2, then every 3 weeks
10 to <20 kg	☐ 600 mg IV at week 1 → 300 mg at week 2, then every 2 weeks
20 to <30 kg	☐ 600 mg IV weekly × 2 → 600 mg at week 3, then every 2 weeks
30 to <40 kg	☐ 600 mg IV weekly × 2 → 900 mg at week 3, then every 2 weeks
40 kg or more	☐ 900 mg IV weekly × 4 → 1,200 mg at week 5, then every 2 weeks
ADULT REGIMENS age 18 and older	
PNH	☐ 600 mg IV weekly × 4 → 900 mg at week 5, then 900 mg every 2 weeks
gMG / aHUS / NMOSD	☐ 900 mg IV weekly × 4 → 1,200 mg at week 5, then 1,200 mg every 2 weeks

BOXED WARNING Life-threatening and fatal meningococcal infections. Vaccinate at least 2 weeks before the first dose unless the delay outweighs the risk — then give antibacterial prophylaxis. Available only through the Soliris REMS.

WHAT WE NEED TO START a missing item here is the most common reason a referral stalls

Every pediatric referral	☐ Signed and completed order ☐ Current weight, measured within 30 days ☐ Patient demographics and insurance ☐ Current medication list ☐ Clinical notes (H&P) supporting the diagnosis ☐ Immunization record ☐ Tried and failed therapy: _____
Soliris	☐ Meningococcal vaccination — serogroups A, C, W, Y AND serogroup B, completed at least 2 weeks before dose 1 ☐ If treatment must start sooner — antibacterial prophylaxis ordered and vaccines given as soon as possible ☐ Prescriber enrolled in the Soliris REMS ☐ Age-appropriate Haemophilus influenzae type b and pneumococcal vaccination (children) ☐ gMG — AChR antibody result and date: _____

PRESCRIBER SIGNATURE required — we cannot schedule without it

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PRESCRIBER SIGNATURE	DATE	DISPENSE AS WRITTEN
X		☐ Yes

Doses shown are from current FDA labeling. Weight is required on every pediatric referral — we cannot schedule without it.

LIVbetter INFUSIONS

PEDIATRIC REFERRAL & ORDER

Ultomiris *ravulizumab*

P: 331-236-0610 | F: 331-314-8989 Fax with insurance cards + clinical notes

FDA-labeled ages: PNH and aHUS — 1 month+ and at least 5 kg · gMG and NMOSD — adults, at least 40 kg **Route:** IV infusion

PATIENT

PATIENT NAME	DATE OF BIRTH	AGE	SEX

WEIGHT (kg) — REQUIRED	DATE WEIGHED	ALLERGIES	STATUS
			☐ New ☐ Continuing

PARENT / GUARDIAN NAME	RELATIONSHIP	BEST PHONE	LANGUAGE

REFERRING PRESCRIBER & INSURANCE

PRESCRIBER NAME	NPI #	PHONE	FAX

PRIMARY INSURANCE	POLICY #	GROUP #	NEXT TREATMENT DATE

DIAGNOSIS ICD-10 required — check all that apply

COMPLEMENT-MEDIATED

☐ D59.5 Paroxysmal nocturnal hemoglobinuria
☐ D59.31 Infection-associated hemolytic-uremic syndrome
☐ D59.32 Hereditary hemolytic-uremic syndrome
☐ D59.39 Other hemolytic-uremic syndrome

NEUROMUSCULAR

☐ G70.00 / G70.01 Myasthenia gravis (adults)
☐ G36.0 NMOSD (adults)
☐ Other: _____

OTHER ICD-10	PRIMARY DIAGNOSIS DESCRIPTION

DOSE one loading dose, then maintenance starting 2 weeks later at the interval shown

WEIGHT BANDS — PNH AND aHUS ONLY age 1 month and older, at least 5 kg	
5 to <10 kg	☐ Loading 600 mg IV → maintenance 300 mg IV every 4 weeks
10 to <20 kg	☐ Loading 600 mg IV → maintenance 600 mg IV every 4 weeks
20 to <30 kg	☐ Loading 900 mg IV → maintenance 2,100 mg IV every 8 weeks
30 to <40 kg	☐ Loading 1,200 mg IV → maintenance 2,700 mg IV every 8 weeks
WEIGHT BANDS — ALL INDICATIONS PNH, aHUS, and gMG / NMOSD in adults	
40 to <60 kg	☐ Loading 2,400 mg IV → maintenance 3,000 mg IV every 8 weeks
60 to <100 kg	☐ Loading 2,700 mg IV → maintenance 3,300 mg IV every 8 weeks
100 kg or more	☐ Loading 3,000 mg IV → maintenance 3,600 mg IV every 8 weeks

BOXED WARNING Life-threatening and fatal meningococcal infections. Vaccinate at least 2 weeks before the first dose unless the delay outweighs the risk — then give antibacterial prophylaxis. Available only through the Ultomiris REMS.

WHAT WE NEED TO START a missing item here is the most common reason a referral stalls

Every pediatric referral	☐ Signed and completed order ☐ Current weight, measured within 30 days ☐ Patient demographics and insurance ☐ Current medication list ☐ Clinical notes (H&P) supporting the diagnosis ☐ Immunization record ☐ Tried and failed therapy: _____
Ultomiris	☐ Meningococcal vaccination — serogroups A, C, W, Y AND serogroup B, completed at least 2 weeks before dose 1 ☐ If treatment must start sooner — antibacterial prophylaxis ordered and vaccines given as soon as possible ☐ Prescriber enrolled in the Ultomiris REMS ☐ Age-appropriate Haemophilus influenzae type b and pneumococcal vaccination (children) ☐ Switching from Soliris? ☐ yes ☐ no — give the Ultomiris loading dose 2 weeks after the last Soliris dose

PRESCRIBER SIGNATURE required — we cannot schedule without it

By signing, you authorize LIVbetter Infusions to act as your prior authorization and specialty pharmacy designated agent with insurance companies and to select the site of care.

PRESCRIBER SIGNATURE	DATE	DISPENSE AS WRITTEN
X		☐ Yes

Doses shown are from current FDA labeling. Weight is required on every pediatric referral — we cannot schedule without it.

LIVbetter INFUSIONS

PEDIATRIC REFERRAL & ORDER

Injectafer *ferric carboxymaltose*

P: 331-236-0610 | F: 331-314-8989 Fax with insurance cards + clinical notes

FDA-labeled ages: Iron deficiency anemia — 1 year and older **Route:** IV infusion or slow IV push

PATIENT

PATIENT NAME	DATE OF BIRTH	AGE	SEX

WEIGHT (kg) — REQUIRED	DATE WEIGHED	ALLERGIES	STATUS
			☐ New ☐ Continuing

PARENT / GUARDIAN NAME	RELATIONSHIP	BEST PHONE	LANGUAGE

REFERRING PRESCRIBER & INSURANCE

PRESCRIBER NAME	NPI #	PHONE	FAX

PRIMARY INSURANCE	POLICY #	GROUP #	NEXT TREATMENT DATE

DIAGNOSIS ICD-10 required — check all that apply

IRON DEFICIENCY

☐ D50.0 Iron deficiency anemia secondary to blood loss
☐ D50.8 Other iron deficiency anemias
☐ D50.9 Iron deficiency anemia, unspecified
☐ E61.1 Iron deficiency without anemia

CONTRIBUTING

☐ N92.0 Heavy menstrual bleeding
☐ K50.- / K51.- Inflammatory bowel disease
☐ K90.0 Celiac disease
☐ Other: _____

OTHER ICD-10	PRIMARY DIAGNOSIS DESCRIPTION

DOSE two doses at least 7 days apart make one course

PEDIATRIC age 1 year and older

All pediatric patients	☐ 15 mg/kg IV × 2 doses, given at least 7 days apart — maximum 750 mg per dose Calculated dose: _____ mg per dose

ADULT for reference if the patient transitions

50 kg or more	☐ 750 mg IV × 2 doses ≥7 days apart ☐ 15 mg/kg once, up to 1,000 mg
Under 50 kg	☐ 15 mg/kg IV × 2 doses, at least 7 days apart

WHAT WE NEED TO START a missing item here is the most common reason a referral stalls

Every pediatric referral	☐ Signed and completed order ☐ Current weight, measured within 30 days ☐ Patient demographics and insurance ☐ Current medication list ☐ Clinical notes (H&P) supporting the diagnosis ☐ Immunization record ☐ Tried and failed therapy: _____
Injectafer	☐ Hemoglobin: _____ g/dL ☐ Ferritin: _____ ng/mL ☐ TSAT: _____ % ☐ Oral iron intolerance or inadequate response documented ☐ Baseline phosphate — symptomatic hypophosphatemia can occur, sometimes weeks after dosing ☐ Source of blood loss evaluated ☐ Weight

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PRESCRIBER SIGNATURE	DATE	DISPENSE AS WRITTEN
X		☐ Yes