Center for Infusion Care
HILLSDALE HOSPITAL
Phone: (517) 212-4336 | **Fax:** (877) 249-1191
hillsdalehospital.com/infusion

☐ **STAT REFERRAL**

RHEUMATOLOGY ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI____ DOB:_____

HT: _____ in WT: _____ kg Sex : ☐ Male ☐ Female Allergies: ☐ NKDA, _____

_____

Physician Name_____ Contact Name _____ Contact Phone # _____

NPI #:_____ Tax ID#:_____ Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD-10 Code plus Description)

_____

PERTINENT MEDICAL HISTORY

Does patient have venous access? ☐ **YES** ☐ **NO** **If yes, what type** ☐ **MEDIPORT** ☐ **PIV** ☐ **PICC LINE** ☐ **OTHER:**_____

1) TB test performed? ○ Yes ○ No Date:_____ Results,_____ ***TB testing will be completed per ACR Guidelines and hospital policy.***

2) Hep-B antigen surface antibody test? ○ Yes ○ No Date: _____

3) Patient previously treated with any of the following: (please select) ○ Remicade ○ Inflectra ○ Simponi Aria ○ Benlysta ○ Rituxan ○ Orencia ○ Actemra ○ Stelara, Date: _____

PRESCRIPTION ORDERS:

a) ALL MEDIPORTS / IV ACCESSES WILL BE FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL POLICY

b) ALL PRODUCTS WILL BE PREPARED AND ADMINISTERED FOLLOWING HOSPITAL POLICY

c) DOSES MAY BE ROUNDED TO NEAREST VIAL SIZE WITHIN 10% OF PRESCRIBED DOSE. WEIGHT BASED DOSING WILL REMAIN FOR DURATION OF ORDER UNLESS WEIGHT CHAGES +/- BY _____%

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY	DURATION
☐	**Actemra**	____mg X ____kg= _____mg	IV	Every_____Weeks	
☐	**Benlysta Loading Dose(s)**	10mg X _____kg= _____mg	IV	0, 2, 4 Weeks, Then Once Every 4 Weeks	
☐	**Benlysta Maintenance Dose**	10mg X _____kg= _____mg	IV	Once Every 4 Weeks	
☐	**Inflectra Loading Dose(s)**	____mg X ____kg= _____mg	IV	0, 2, 6 Weeks, Then Once Every_____Weeks	
☐	**Inflectra Maintenance Dose(s)**	____mg X ____kg= _____mg	IV	Once Every_____Weeks	
☐	**Krystexxa**	8 mg	IV	Once Every 4 Weeks	
☐	**Orencia Loading Dose(s)**	_____mg	IV	0, 2, 4 Weeks, Then Once Every 4 Weeks	
☐	**Orencia Maintenance Dose(s)**	500 mg	IV	Once Every 4 Weeks	
☐	**Orencia Maintenance Dose(s)**	750 mg	IV	Once Every 4 Weeks	
☐	**Orencia Maintenance Dose(s)**	1000 mg	IV	Once Every 4 Weeks	
☐	**Remicade Loading Dose(s)**	____mg X ____kg= _____mg	IV	0, 2, 6 Weeks, Then Once Every_____Weeks	
☐	**Remicade Maintenance Dose(s)**	____mg X ____kg= _____mg	IV	Once Every_____Weeks	
☐	**Rituxan**	____mg X ____kg= _____mg	IV	Once Every_____Weeks	
☐	**Simponi Aria**	____mg X ____kg= _____mg	IV	Once Every_____Weeks	
☐	**Stelara Loading Dose(s)** **SC administration is NOT covered Outpatient*	_____mg	IV	Once	1

PREMEDS

SELECT	MEDICATION	DOSE	ROUTE
☐	**NONE**	NA	NA
☐	**BENADRYL**		
☐	**ACETAMINOPHEN**		
☐	**OXYGEN**		
☐	**SOLU-MEDROL**		
☐	**ONDANSETRON**		
☐	**FAMOTIDINE**		
☐	**Other:**		
☐	**Other:**		
☐	**Other:**		

LABS

SELECT	LAB REQUESTED	WHEN	FREQUENCY
☐	**NONE**	NA	NA
☐	**BMP**		
☐	**CMP**		
☐	**BUN/CREATININE**		
☐	**CRP**		
☐	**ESR**		
☐	**ALT**		
☐	**AST**		
☐	**LIVER PANEL**		
☐	**OTHER:**		

Physician's Signature _____ **Time**_____ **Date**_____
**Signature Must Be Legible*

.Cosignature (If Required)_____ **Time**_____ **Date**_____
**Signature Must Be Legible*

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.