NEPHROLOGY

☐ New Prescription/Referral
☐ Prescription Refill

 # Of Refills:

Rx: **Patient Name:** **Patient Weight:** kg **DOB:**

Diagnosis:

ICD-10 Code:

Soliris (eculizumab):

☐ *paroxysmal nocturnal hemoglobinuria (PNH)
☐ 600mg IV infusion Qweek for the 1st 4 weeks, then
☐ 900mg IV infusion as a fifth dose 1 week later, then
☐ 900mg IV infusion Q 2weeks.

☐ *atypical hemolytic uremic syndrome (aHUS)
☐ 900mg IV infusion Qweek for the 1st 4 weeks, then
☐ 1200mg IV infusion as a fifth dose 1 week later, then
☐ 1200mg IV infusion Q 2weeks.

Diagnosis:

ICD-10 Code:

☐ **Krystexxa (pegloticase):**

☐ 8mg via IV infusion for at least 120mins Q2wks on a 250ml NS at room temperature
☐ Observe for 1 hour after infusion ☐ Discontinue treatment if uric acid level to > 6mg/dL
☐ Other orders: _____

Diagnosis:

ICD-10 Code:

IVIG:

☐ Ok to use biosimilar

☐ Gamunex (10%) ☐ Privigen (10%) ☐ Octagam (10%) ☐ Gammaplex (10%)
☐ Gammagard (10%) ☐ Bivigam (10%) ☐ Gammaked(10%) ☐ Flebogamma DIF (10%)
☐ Asceniv (10%) ☐ Panzyga (10%) ☐ Other Orders:_____

☐ **Dosage:** ☐ _____g/day IV ☐ _____g/kg IV ☐ Over_____# of days ☐ _____# of months
☐ **Frequency:** ☐ One-Time Only ☐ every _____ weeks (Optional: Start Date _____)

Kidney Transplant
ICD-10 Code:

☐ **Nulojix (belatacept):**

☐ Initial Phase: 10mg/kg for 30 mins via IV Infusion
☐ Maintenance Phase: 5mg/kg for 30 mins via IV Infusion every 4 weeks (+/-3 days)
☐ Other orders: _____

Diagnosis:

ICD-10 Code:

☐ **Injectafer:** (◯ 1st Choice)

☐ **1st Dose:** 750mg IV infusion in no more than 250ml of 0.9% NaCl over at least 15 mins
☐ **2nd Dose:** 7 days after the 1st dose, 750mg IV infusion in no more than 250ml of 0.9% NaCl over at least 15 mins or slow IV push over 7.5 mins

☐ **Venofer:** (◯ 1st Choice)

☐ 200mg in 100ml NaCl over 15 mins x 5 doses via IV infusion over a 14-day period. Total = 1000mg.
☐ 200mg IV push over 2 to 5 mins x 5 doses over a 14-day period. Total = 1000mg.

☐ **Ferrlecit:**

☐ 125mg in 100ml NaCl over 1hr via IV infusion 48-72 hrs apart x8 doses.

☐ Other orders: _____

Diagnosis:

ICD-10 Code:

Rituximab: ☐ **Rituxan** ☐ **Ruxience** ☐ **Riabni** ☐ **Truxima**

☐ Ok to use biosimilar

☐ **Dosage:** ☐ 1000mg ☐ 500mg ☐ Other:_____ ☐ 375 mg/m2

☐ **Frequency:** ☐ one time dose ☐ Weekly x 4 weeks ☐ Other:_____ ☐ Repeat dose in 2 weeks ☐ Repeat after 6 months

☐ Other orders: _____

Pre-Medication:

☐ Solumedrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Others: _____

☐ Tylenol _____ mg PO
☐ 650 mg ☐ 975 mg

☐ Benadryl _____ mg PO
☐ 25 mg ☐ IV
☐ 50 mg ☐ PO

ANA Kit Protocol:

☐ OK to use

Physician Signature **NPI #:** **DATE:(Valid for 1 year)**

By affixing my signature, I confirm the medical necessity of the aforementioned therapy, products, and services, as well as my responsibility for the patient's care. I have obtained consent to disclose the mentioned details and any relevant medical or patient information concerning this treatment. I grant the pharmacy permission to contact the insurance company on my behalf to secure authorization for the patient.

PHYSICIAN INFORMATION

Physician Name: **Clinic:**

Phone: **Fax:** **Email:** **Other:**

Office Mailing Address:

Please include the following

☐ Patient demographics ☐ Insurance attached ☐ Diagnosis(supporting) ☐ History & Physical
☐ Lab Results ☐ Clinical progress notes ☐ Medication list ☐ Other Test Results

☐ Baseline serum uric acid & G6PD serum level: (Krystexxa)
☐ CBC, Hep B surface antigen & Hep B core antibody total (not IgM): (Rituximab)
☐ TB Results within 12 months: (Nulojix) ☐ EBV serostatus: (Nulojix)
☐ CBC, Iron, Transferrin, Ferritin, TIBC (Iron)
☐ Creatinine: (IVIG)
☐ MenACWY and Men B vaccines (Soliris)

***If TB or Hep B results are positive - please provide documentation of treatment or medical clearance & a negative CXR (TB+)**