

## NEPHROLOGY

- ☐
- New Prescription/Referral
- 
- ☐
- Prescription Refill

# Of Refills:

Rx:

Patient Name:Patient Weight:

kg

DOB:

Diagnosis:

**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.

ICD-10 Code:

Diagnosis:

**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 &gt; 6mg/dL

ICD-10 Code:

Other orders: \_\_\_\_\_

Diagnosis:

**IVIG:**

Gamunex (10%)

Privigen (10%)

Octagam (10%)

Gammaplex (10%)

Ok to use  
biosimilar

Gammagard (10%)

Bivigam (10%)

Gammaked(10%)

Flebogamma DIF (10%)

Asceniv (10%)

Panzyga (10%)

Other Orders: \_\_\_\_\_

ICD-10 Code:

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 InfusionMaintenance Phase: 5mg/kg for 30 mins via IV Infusion every 4 weeks (+/-3 days)

Other orders: \_\_\_\_\_

Diagnosis:

**Injectafer:**1st Dose: 750mg IV infusion in no more than 250ml of 0.9% NaCl over at least 15 mins

( 1st Choice)

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:**

200mg in 100ml NaCl over 15 mins x 5 doses via IV infusion over a 14-day period. Total

( 1st Choice)

= 1000mg.

200mg IV push over 2 to 5 mins x 5 doses over a 14-day period. Total = 1000mg.

ICD-10 Code:

**Ferrlecit:**

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

Other orders: \_\_\_\_\_

Diagnosis:

**Rituximab:****Rituxan****Ruxience****Riabni****Truxima**Ok to use  
biosimilarDosage:

1000mg

500mg

Other: \_\_\_\_\_

375 mg/m2

Frequency:

one time dose

Weekly x 4 weeks

Other: \_\_\_\_\_

Repeat dose in 2 weeks

Repeat after 6 months

ICD-10 Code:

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 &amp; Physical

Lab Results

Clinical progress notes

Medication list

Other Test Results

Baseline serum uric acid &amp; G6PD serum level: (Krystexxa)

CBC, Iron, Transferrin, Ferritin, TIBC (Iron)

CBC, Hep B surface antigen &amp; Hep B core antibody total (not IgM): (Rituximab)

Creatinine: (IVIG)

TB Results within 12 months: (Nulojix)

EBV serostatus: (Nulojix)

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+)**