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) Patient diagnosed with Congestive Heart Failure? ○ Yes ○ No 3) Liver function test normal? ○ Yes ○ No 4) Hep-B antigen surface antibody test? ○ Yes ○ No Date: _____

4) 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 PROTOCOL

b) ALL PRODUCTS WILL BE PREPARED AND ADMINISTERED PER STANDARD PHARMACY CONCENTRATIONS AND HOSPITAL POLICY

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

Select	MEDICATION	DOSE	ROUTE	FREQUENCY	DURATION
	ACTEMRA	_____ MG / ____KG= _____ MG		EVERY _____ WEEKS	
	BENLYSTA LOADING DOSES	10 MG / _____KG= _____ MG	IV	0, 2, 4 WEEKS, THEN ONCE EVERY 4 WEEKS	
	BENLYSTA MAINTENANCE DOSES	10 MG / _____KG= _____ MG	IV	ONCE EVERY 4 WEEKS	
	BENLYSTA MAINTENANCE DOSES	200 mg	SC	ONCE WEEKLY	
	INFLECTRA LOADING DOSES	_____ MG / ____KG= _____ MG	IV	0, 2, 6 WEEKS, THEN ONCE EVERY ____ WEEKS	
	INFLECTRA MAINTENANCE DOSES	_____ MG / ____KG= _____ MG	IV	ONCE EVERY _____ WEEKS	
	KRYSTEXXA	8 mg	IV	ONCE EVERY 2 WEEKS	
	ORENCIA (LOADING DOSES)	____ mg	IV	0, 2, 4 WEEKS, THEN ONCE EVERY 4 WEEKS	
	ORENCIA MAINTENANCE DOSES	500 mg	IV	EVERY 4 WEEKS	
	ORENCIA MAINTENANCE DOSES	750 mg	IV	EVERY 4 WEEKS	
	ORENCIA MAINTENANCE DOSES	1000 mg	IV	EVERY 4 WEEKS	
	REMICADE LOADING DOSES	_____ MG / ____KG= _____ MG	IV	0, 2, 6 WEEKS, THEN ONCE EVERY ____ WEEKS	
	REMICADE MAINTENANCE DOSES	_____ MG / ____KG= _____ MG	IV	ONCE EVERY _____ WEEKS	
	RITUXAN	_____ MG / ____KG= _____ MG	IV	EVERY _____ WEEKS	
	SIMPONI ARIA	_____ MG / ____KG= _____ MG	IV	EVERY _____ WEEKS	
	STELARA LOADING DOSES	45 Mg	SC	0, 4 WEEKS, THEN ONCE EVERY 12 WEEKS	
	STELARA MAINTENANCE DOSES	45 Mg	SC	ONCE EVERY 12 WEEKS	
	STELARA LOADING DOSES	90 Mg	SC	0, 4 WEEKS, THEN ONCE EVERY 12 WEEKS	
	STELARA MAINTENANCE DOSES	90 Mg	SC	ONCE EVERY 12 WEEKS	

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**_____

Cosignature (If Required)_____ **Time**_____ **Date**_____

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