SEMINOLE HOSPITAL DISTRICT
INFUSION CENTER
Phone: 432-758-4716 Fax: 877-249-1191

☐ **STAT REFERRAL**

RHEUMATOLOGY ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____ DOB:_____

HT: _____ in WT: _____ kg Birth Sex :( ) Male ( ) Female Allergies: ( ) NKDA, (Or):_____

_____

Provider 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,_____

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 PER HOSPITAL PROTOCOL PRN UNLESS OTHERWISE NOTED BY PROVIDER

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 PRESCRIBED DOSE. WEIGHT BASED DOSING TO REMAIN UNLESS WEIGHT CHANGES +/- BY____ %

d) BIOSIMILAR EQUIVALENT SUBSTITUTION MAY APPLY

Select	MEDICATION	DOSE	ROUTE	FREQUENCY	DURATION
	Actemra (Max Dose = 800mg)	**mg/kg**	**IV**	**Every 4 Weeks**	
	Benlysta Loading Dose(s)	**10 mg / kg**	**IV**	**0, 2, 4 Weeks, Then Once Every 4 Weeks**	
	Benlysta Maintenance Dose	**10 mg / kg**	**IV**	**Once Every 4 Weeks**	
	Krystexxa	**8 mg**	**IV**	**Once Every 2 Weeks**	
	Orencia Loading Dose(s)	**mg**	**IV**	**0, 2, 4 Weeks, Then Once Every 4 Weeks**	
	Orencia Maintenance Dose(s)	**mg**	**IV**	**Once Every 4 Weeks**	
	Remicade (infliximab) Loading Dose(s)	**mg / kg**	**IV**	**0, 2, 6 Weeks, Then Once Every Weeks**	
	Remicade (infliximab) Maintenance Dose(s)	**mg / kg**	**IV**	**Once Every Weeks**	
	Rituxan	**mg / kg**	**IV**	**Once Every Weeks**	
	Simponi Aria	**mg / kg**	**IV**	**Once Every Weeks**	
	Stelara Loading Dose(s) ***Sub Q administration is NOT covered Outpatient***	**mg**	**IV**	**Once**	**1**

PREMEDS

SELECT	MEDICATION	DOSE	ROUTE
	NONE	**NA**	**NA**
	BENADRYL (diphenhydramine)		
	TYLENOL (acetaminophen)		
	PEPCID (famotidine)		
	SOLU-MEDROL (methylprednisolone)		
	ZOFRAN (ondansetron)		
	Other:		
	Other:		
	Other:		
	OXYGEN:		

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 Clear and Legible*

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

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