NEPHROLOGY ORDER FORM
P: 240.200.4464 F: 240.892.3005

PATIENT INFORMATION: Fax completed form, insurance information, and clinical documentation to 240.892.3005

Patient Name: _____ DOB: _____ Phone: _____

MEDICAL INFORMATION

Patient Weight: _____ lbs./kg. (required) Allergies: _____

THERAPY ORDER

Diagnosis	Medication Orders	
☐ Iron Deficiency Anemia ☐ Iron Deficiency Anemia with CKD not on dialysis **ICD-10 Code:** _____	****If the patient has Aetna, Cigna, Humana, or UHC, the patient must try and fail Venofer first**** ☐ **Venofer** 200mg IV – Administer 5 doses over a 14-day period ☐ **Venofer** 200mg IV weekly x 5 weeks ☐ **Injectafer** 15mg/kg IV (<50kg) – Give 2 doses at least 7 days apart ☐ **Injectafer** 750mg IV (>50kg) – Give 2 doses at least 7 days apart ☐ **Monoferric** 20mg/kg IV x 1 dose (<50kg) ☐ **Monoferric** 1000mg IV x 1 dose (>50kg)	
☐ Chronic Gouty Arthropathy w/tophus (tophi) ☐ Chronic Arthropathy w/o mention of tophus (tophi) **ICD-10 Code:** _____	☐ **Krystexxa** 8mg IV every 2 weeks Pre-medication protocol: Benadryl 50mg IV/PO & Solu-Medrol 125mg IV ☐ Other orders: _____	**Refills** ☐ _____ ☐ x 1 year
☐ X-linked hypophosphatemia **ICD-10 Code:** _____	☐ **Cryvista** 1mg/kg SubQ rounded to the nearest 10mg, every 4 weeks ☐ **Cryvista** _____ mg/kg SubQ Frequency: _____ ****MAX DOSE 90mg****	**Refills** ☐ _____ ☐ x 1 year
☐ Diagnosis: _____ **ICD-10 Code:** _____	☐ **Rituximab or Rituximab biosimilar** depending on patient's insurance **Dose:** ☐ 1000mg **OR** ☐ 375mg/m² **OR** ☐ Other: _____ **Frequency:** ☐ One-time dose **OR** ☐ Weekly x 4 weeks **OR** ☐ Day 0, Repeat dose in 2 weeks **OR** Other: _____ ☐ Do not substitute. Brand: _____ Pre-medication protocol: Benadryl 50mg IV / PO & Solu-Medrol 100mg IV	**Refills** ☐ _____ ☐ x 1 year
☐ Kidney Transplant **ICD-10 Code:** _____	☐ **Nulojix** _____ mg IV every 4 weeks ☐ Other: _____	**Refills** ☐ _____ ☐ x 1 year
☐ Diagnosis: _____ **ICD-10 Code:** _____	☐ **IVIg** Orders: _____ mg/kg **OR** _____ mg/kg IV divided over _____ day(s) **Frequency**: Every _____ weeks x 1 year **OR** _____ one time dose only Preferred Brand: _____ *Active Infusions to choose if not indicated*	**Refills** ☐ _____ ☐ x 1 year

Premedication orders: Tylenol ☐ 1000mg OR ☐ 500 mg PO
Please choose one antihistamine: ☐ Diphenhydramine 25mg PO ☐ Loratadine 10mg PO ☐ Cetirizine 10mg PO ☐ Other: _____
Additional premedications: ☐ Solu-Medrol _____ mg IVP ☐ Solu-Cortef _____ mg IVP ☐ Other: _____

Please provide patient's demographic information, insurance information, medication list, and clinical notes. Active Infusions will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and assist them in enrolling in any available co-pay assistance programs as needed/applicable. Thank you for the referral.

PROVIDER INFORMATION

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____