ACTIVE infusions

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: _____

Diagnosis	Medication Orders	Refills
□ 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: _____	□ _____ □ 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****	□ _____ □ 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	□ _____ □ x 1 year
□ Kidney Transplant **ICD-10 Code:** _____	□ Nulojix _____ mg IV every 4 weeks □ Other: _____	□ _____ □ 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*	□ _____ □ x 1 year

Premedication orders: Tylenol □ 1000mg □ 650 mg PO OR □ 500 mg PO
Please choose one antihistamine: □ Diphenhydramine 25mg PO/IV □ Diphenhydramine 50mg PO/IV □ Loratadine 10mg PO □ Cetirizine 10mg PO □ Other: _____

Additional premedications: □ Solu-Medrol _____ mg IVP □ Solu-Cortef _____ mg IVP □ Other: _____

PROVIDER INFORMATION

Please provide the patient's demographic information, insurance information, medication list, and clinical notes. Active Infusions will complete insurance verification and submit required documentation for approval. Thank you for the referral.

Provider Name: _____ Signature: _____ Date: _____

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