



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
<input type="checkbox"/> Iron Deficiency Anemia <input type="checkbox"/> 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** <input type="checkbox"/> Venofer 200mg IV - Administer 5 doses over a 14-day period <input type="checkbox"/> Venofer 200mg IV weekly x 5 weeks <input type="checkbox"/> Injestafer 15mg/kg IV (<50kg) - Give 2 doses at least 7 days apart <input type="checkbox"/> Injestafer 750mg IV (>50kg) - Give 2 doses at least 7 days apart <input type="checkbox"/> Monoferric 20mg/kg IV x 1 dose (<50kg) <input type="checkbox"/> Monoferric 1000mg IV x 1 dose (>50kg)	
<input type="checkbox"/> Chronic Gouty Arthropathy w/tophus (tophi) <input type="checkbox"/> Chronic Arthropathy w/o mention of tophus (tophi) ICD-10 Code: _____	<input type="checkbox"/> Krystexxa 8mg IV every 2 weeks Pre-medication protocol: Benadryl 50mg IV/PO & Solu-Medrol 125mg IV <input type="checkbox"/> Other orders: _____	<input type="checkbox"/> _____ <input type="checkbox"/> x 1 year
<input type="checkbox"/> X-linked hypophosphatemia ICD-10 Code: _____	<input type="checkbox"/> Cryvista 1mg/kg SubQ rounded to the nearest 10mg, every 4 weeks <input type="checkbox"/> Cryvista _____ mg/kg SubQ Frequency: _____ **MAX DOSE 90mg**	<input type="checkbox"/> _____ <input type="checkbox"/> x 1 year
Diagnosis: _____ ICD-10 Code: _____	<input type="checkbox"/> Rituximab or Rituximab biosimilar depending on patient's insurance Dose: <input type="checkbox"/> 1000mg OR <input type="checkbox"/> 375mg/m ² OR <input type="checkbox"/> Other: _____ Frequency: <input type="checkbox"/> One-time dose OR <input type="checkbox"/> Weekly x 4 weeks OR <input type="checkbox"/> Day 0, Repeat dose in 2 weeks OR Other: _____ <input type="checkbox"/> Do not substitute. Brand: _____ Pre-medication protocol: Benadryl 50mg IV/PO & Solu-Medrol 100mg IV	<input type="checkbox"/> _____ <input type="checkbox"/> x 1 year
<input type="checkbox"/> Kidney Transplant ICD-10 Code: _____	<input type="checkbox"/> Nulojix _____ mg IV every 4 weeks <input type="checkbox"/> Other: _____	<input type="checkbox"/> _____ <input type="checkbox"/> x 1 year
Diagnosis: _____ ICD-10 Code: _____	<input type="checkbox"/> 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: _____ <i>Active Infusions to choose if not indicated</i>	<input type="checkbox"/> _____ <input type="checkbox"/> 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: _____

ACTIVE INFUSIONS | Patient Demographics Request

Dear Provider / Office Staff,

We have received a referral for the above patient and will be reaching out to begin the scheduling process. To ensure we are able to make contact in a timely manner, we kindly ask that your office confirm or complete the patient demographic information below. This helps us verify accurate contact details prior to outreach and avoid any delays in care.

Please complete and return via fax to 240-892-3005 or email kendrick@activeinfusions.com. Thank you!

PATIENT CONTACT INFORMATION

Please confirm or provide the most current contact information you have on file for this patient.

Patient Name

Last, First MI

Date of Birth

MM / DD / YYYY

Primary Phone Number

Best phone number

Alternate Phone Number

Alternate number

Email Address

Patient email address

Patient's Preferred Method of Contact:

Phone Call Text Message Email No Preference

EMERGENCY CONTACT

Required for ALL patients receiving therapy for Alzheimer's Disease

Emergency Contact Name

Full name

Relationship to Patient

e.g. Spouse, Child, Friend

Emergency Contact Phone

Phone number

Emergency Contact Email

Email (if available)

PRIMARY INSURANCE: SUBSCRIBER INFORMATION

Please confirm the subscriber / policy holder information for the patient's primary insurance.

Is the patient the Subscriber / Policy Holder?

Yes No

Subscriber / Policy Holder Name

Full name

Relationship to Patient

e.g. Self, Spouse, Parent

Subscriber Date of Birth

MM / DD / YYYY

Subscriber Member ID

Member ID

Insurance Company

Insurance name

Group Number

Group number

COPAY ASSISTANCE PROGRAM

If the patient is enrolled in a manufacturer copay or patient assistance program, please provide details if available.

Program Name

Program name

Program ID Number

ID number on card

NOTES / ADDITIONAL INFORMATION