BARNES HEALTHCARE SERVICES

Arthritis and Inflammatory – Intravenous Order Form

Please fax all pages of completed form to our Intake team at 888.276.7948
Contact our Intake team 800.422.5059 ext.1480

1 Patient Information — Please provide copies of front and back of all medical and prescription insurance cards.

☐ New patient ☐ Current patient
Patient's first name _____ **Last name** _____ **MI** _____
Preferred patient first name _____ **Preferred patient last name** _____
Sex at birth: ☐ Male ☐ Female **Gender identity** _____ **Pronouns** _____
Last 4 of SSN _____ **Date of birth** _____/_____/_____
Street address _____ **Apt #** _____
City _____ **State** _____ **Zip** _____
Home phone _____ **Cell phone** _____ **Email address** _____
Parent/guardian (if applicable)
Home phone _____ **Cell phone** _____ **Email address** _____
Alternate caregiver/contact
Home phone _____ **Cell phone** _____ **Email address** _____
☐ OK to leave message with alternate caregiver/contact
Patient's primary language: ☐ English ☐ Other **If other, please specify** _____

Provider will read the following statement to patient: By providing the phone number(s) and email address above, you consent to receiving automated/artificial voice calls, emails and/or text messages from Barnes Healthcare Services about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies.

2 Prescriber Information — All fields must be completed to expedite prescription fulfillment.

Date _____ **Time** _____ **Date medication needed** _____/_____/_____
Office/clinic/institution name
Prescriber's first name _____ **Last name** _____
Prescriber's title _____ **If NP or PA, under direction of Dr.** _____
Office phone _____ **Fax** _____ **NPI #** _____ **License #** _____
Office contact and title _____ **Office contact email** _____
Office street address _____ **Suite #** _____
City _____ **State** _____ **Zip** _____
Infusion location: ☐ Patient's home ☐ Prescriber's office ☐ Infusion site
If infusion site, complete information below:
Infusion site name _____ **Clinic/hospital affiliation** _____
Site street address _____ **Suite #** _____
City _____ **State** _____ **Zip** _____
Infusion site contact _____ **Phone** _____ **Fax**
Email _____
Note: Check the appropriate shipment options in Section 4: Prescribing Information.

3 Clinical Information

Primary ICD-10 code (REQUIRED): _____

Has the patient been treated previously for this condition? ☐ Yes ☐ No

Is patient currently on therapy? ☐ Yes ☐ No

Please list all therapies tried/failed: _____

Patient wt _____ **Date wt obtained:** _____/_____/_____

☐ NKDA **Known drug allergies:** _____

Concurrent meds: _____

4 Prescribing Information

INFUSION LOCATION: ☐ Patient's home ☐ Healthcare facility

Medication	Strength / Formulation	Directions	Fluids for administration & reconstitution (strike through if not required)	Quantity / Refills
Actemra® (tocilizumab)	☐ 80mg/4mL single-dose vial (SDV) ☐ 200mg/10mL SDV ☐ 400mg/20mL SDV	Rheumatoid Arthritis (RA): ☐ 4mg/kg IV infusion every 4 weeks. Max 800mg/infusion. ☐ 8mg/kg IV infusion every 4 weeks. Max 800mg/infusion. Polyarticular Juvenile Idiopathic Arthritis (PJIA): ☐ 10mg/kg IV every 4 weeks (≥2 yrs, <30kg) ☐ 8mg/kg IV every 4 weeks (≥2 yrs, ≥30kg) Systemic JIA (SJIA) and Cytokine Release Syndrome: ☐ 12mg/kg IV every 2 weeks (≥2 yrs, <30kg). Max 800mg. ☐ 8mg/kg IV every 2 weeks (≥2 yrs, ≥30kg). Max 800mg.	Dilute desired dose with normal saline to total desired volume to be infused over 1 hour. ☐ NS 0.9% 100mL >30kg ☐ NS 0.9% 50mL <30kg	☐ 28-day supply ☐ 84-day supply ☐ Refill x 1 year unless noted otherwise ☐ Other _____ Refills _____
Orencia® (abatacept)	250mg SDV	Rheumatoid Arthritis and Psoriatic Arthritis: ☐ 500mg IV (<60kg) ☐ 750mg IV (60–100kg) ☐ 1000mg IV (>100kg) Juvenile Idiopathic Arthritis: ☐ 10mg/kg IV (<75kg) ☐ 750mg IV (75–100kg) ☐ 1000mg IV (>100kg)	Reconstitute each vial of Orencia with 10mL of sterile water. Dilute desired dose to total 100mL in normal saline, infuse over 30 minutes.	Loading dose: 3 doses · No refills Maintenance dose: ☐ 28-day supply ☐ Refill x 1 year unless noted otherwise ☐ Other _____ Refills _____

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Medication	Strength / Formulation	Directions	Fluids for administration & reconstitution (strike through if not required)	Quantity / Refills
		☐ Loading dose: at week 0, 2 and 4, then every 4 weeks ☐ Maintenance dose: every 4 weeks	☐ NS 0.9% 100mL ☐ Sterile Water as needed for reconstitution	
Simponi Aria® (golimumab)	50mg/4mL SDV	☐ Loading dose: 2mg/kg _____ mg IV at week 0, 4 and every 8 weeks ☐ Other _____ ☐ Maintenance dose: 2mg/kg _____ mg IV every 8 weeks ☐ Other _____	Dilute desired dose with normal saline to a total volume of 100mL, infuse over 30 minutes.	Loading dose: 3 doses · No refills Maintenance dose: ☐ 56-day supply ☐ Refill x 1 year unless noted otherwise ☐ Other _____ Refills _____
Other				

If shipped to physician's office or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.

Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE	

Date _____ ☐ Dispense as written Date _____ ☐ Substitution allowed

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

5 Additional Prescribing Information for Home Infusions *Only*

Required medication and supplies for home infusion (please complete this section for home infusions only)

Premedication orders

☐ Acetaminophen 650mg PO 30 min prior to infusion ☐ Diphenhydramine 50mg PO 30 min prior to infusion

☐ Hydrocortisone 100mg IVP 30 min prior to infusion ☐ Other _____

Send quantity and refills sufficient for medication dose and days supply.

Infusion method:

☐ Gravity (Pediatric patients will be given a pump unless noted otherwise) ☐ Prefer Pump

Flushing orders

☐ NS 0.9% Flush (if central venous access, sterile flush will be provided)

Choose administration access: ☐ Peripheral access ☐ Central venous access

If central venous access: Flush with 10mL Sterile NS 0.9% before and after infusion. Follow with heparin 100 units/mL 5mL final flush

If peripheral access: Flush with 3mL NS 0.9% before and after infusion and as needed

Hypersensitivity / Anaphylaxis

☐ Stop infusion

Or Medicate with:

☐ Epinephrine / EpiPen 0.3mg IM as needed for anaphylaxis (for children less than 30kg: Epinephrine 0.15mg)

☐ Start NS 0.9% 100mL at TKO ☐ Diphenhydramine 50mg slow IVP PRN anaphylaxis

☐ Hydrocortisone 100mg slow IVP PRN anaphylaxis ☐ Methylprednisolone 125mg slow IVP PRN anaphylaxis

☐ Diphenhydramine 50mg PO PRN anaphylaxis ☐ Other _____

Skilled nursing visit as needed to establish venous access, administer medication and assess general status and response to therapy.

**If nursing services will be required for therapy administration, the home health nurse will call for additional orders per state regulations.*

Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication.

(S9359, S9379).

Lab Orders CBC/LFT q 6 months

Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE	

Date _____ **☐ Dispense as written** **Date** _____ **☐ Substitution allowed**

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.