BAPTIST | CANCER CENTER

# RHEUMATOLOGY

Phone: (901) 752-6131
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**Patient Demographics**

_____ _____
Last Name First Name Middle Initial Social Security Number

_____ _____ _____ _____
Date of Birth Phone Number Insurance Provider ID Number

**Provider Information**

_____ _____ _____
Referring Provider Name Phone Number Practice Contact (Name)

**Clinical Information**

_____ _____ **Allergies:**_____
Diagnosis ICD-10 code

**Prescriber's Orders: orders expire after 12 months**

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| ☐ | INITIAL **Abatacept (ORENCIA)** _____ mg, Intravenously over 30 minutes, at 0, 2, and 4 weeks, followed by every 4 weeks, for _____ treatments |
| ☐ | MAINTENANCE **Abatacept (ORENCIA)** _____ mg, Intravenously over 30 minutes, Every 4 weeks, for _____ treatments |
| ☐ | **Anifrolumab (SAPHNELO)** 300mg, Intravenously over 30 minutes, Every 4 weeks, for _____ treatments |
| ☐ | INITIAL **Belimumab (BENLYSTA**) 10 mg/kg, Intravenously over 60 minutes, at 0, 2, and 4 weeks, followed by every 4 weeks, for _____ treatments |
| ☐ | MAINTENANCE **Belimumab (BENLYSTA)** 10 mg/kg, Intravenously over 60 minutes, Every 4 weeks, for _____ treatments |
| ☐ | INTIAL **Certolizumab pegol (CIMZIA)**, 400mg, Subcutaneous, Every 2 weeks for 3 doses followed by 200mg every 2 weeks maintenance, for _____ treatments –OR– |
| ☐ | **Certolizumab pegol (CIMZIA)**, 400mg, Subcutaneous, Every 2 weeks for 3 doses followed by 400mg every 4 weeks maintenance, for _____ treatments |
| ☐ | MAINTENANCE **Certolizumab pegol (CIMZIA)**, 200mg, Subcutaneous, Every 2 weeks, for _____ treatments –OR– |
| ☐ | **Certolizumab pegol (CIMZIA)**, 400mg, Subcutaneous, Every 4 weeks, for _____ treatments |
| ☐ | INTIAL **Golimumab (SIMPONI ARIA)** 2mg/kg, Intravenously over 30 minutes, Every 4 weeks x 2 doses, then every 8 weeks, for_____ treatments |
| ☐ | MAINTENANCE **Golimumab (SIMPONI ARIA)** 2mg/kg, Intravenously over 30 minutes, Every 8 weeks, for_____ treatments |
| ☐ | **Immune globulin** _____ g/kg (dosing is based on Ideal Body Weight), Intravenously beginning at 0.5 mg/kg/min and if no reactions, double every 30 minutes to a MAX rate of 8 mg/kg/min for the first infusion. Subsequent infusions may begin at 4 mg/kg/min and if no reactions, increase after 30 minutes to MAX of 8 mg/kg/min, Every ____ weeks, for _____ treatments<br>Pre-medicate with PO diphenhydramine 25mg and PO acetaminophen 650mg, Once, prior to each infusion<br>Note: orders for any IVIG product will automatically interchange to our preferred product |
| ☐ | **Infliximab** ____mg/kg, Intravenously over 90 minutes x 1 dose followed by subsequent infusions over 60 minutes, Every ____ weeks, for _____ treatments<br>Pre-medicate with PO diphenhydramine 25mg and PO acetaminophen 650mg, Once, 30 minutes prior to each infusion<br>Note: orders for infliximab will be automatically interchanged to the preferred biosimilar |
| ☐ | **Natalizumab (TYSABRI)** 300 mg, Intravenously over 60 minutes, Every 4 weeks, for _____ treatments |
| ☐ | **Pegloticase (KRYSTEXXA)** 8mg, Intravenously over 2 hours, Every 2 weeks, for _____ treatments<br>Pre-medicate with PO diphenhydramine 25mg and PO dexamethasone 12mg, Once, 30 minutes prior to each infusion |
| ☐ | **Risankizumab (SKYRIZI)** 600 mg, Intravenously over 60 minutes, Every 4 weeks for 3 treatments |

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| ☐ | **Rituximab** 375 mg/m2, Intravenously titrated beginning at 50 mg/hr and if no reactions, double rate every 30 minutes to a MAX rate of 400mg/hr, Weekly, For 4 treatments<br>--OR-- |
| ☐ | **Rituximab** (circle one): 1000 mg OR 375 mg/m2, Intravenously titrated beginning at 50 mg/hr and if no reactions, double every 30 minutes to a MAX rate of 400mg/hr, Day 1 and Day 15 for two total doses. Repeat every _____ months.<br>Pre-medicate with PO diphenhydramine 25mg, PO acetaminophen 650mg, and IV methylprednisolone 125mg, Once, 30 minutes prior to each infusion<br>Note: orders for rituximab will be automatically interchanged to the preferred biosimilar |
| ☐ | INITIAL **Secukinumab (COSENTYX)** 6 mg/kg, Intravenously over 30 minutes followed by 1.75 mg/kg (MAX 300mg), Intravenously over 30 minutes, Every 4 weeks, for _____ treatments |
| ☐ | MAINTENANCE **Secukinumab (COSENTYX)** 1.75 mg/kg, Intravenously over 30 minutes, Every 4 weeks, for _____ treatments. |
| ☐ | INITIAL **Tildrakizumab (ILUMYA)** 100 mg, Subcutaneous, at 0 and 4 weeks then every 12 weeks, for 4 doses |
| ☐ | MAINTENANCE **Tildrakizumab (ILUMYA)** 100 mg, Subcutaneous, every 12 weeks, for 4 doses |
| ☐ | **Tocilizumab** _____mg/kg, Intravenously over 60 minutes, Every 4 weeks, for _____ treatments |
| ☐ | –OR-<br>**Tocilizumab (ACTEMRA)** 162 mg, Subcutaneous, Every ____ weeks. for _____ treatments<br>Note: orders for tocilizumab IV will be automatically interchanged to the preferred biosimilar |
| ☐ | **Ustekinumab**, _____ mg, Intravenously over 60 minutes, Once (IV loading dose only)<br>Note: orders for ustekinumab will be automatically interchanged to the preferred biosimilar |

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| **Additional Order Comments:** | |

_____ _____ _____

Physician Signature Printed name Date/time

In order to refer a patient to one of the Baptist Infusion Centers, please send the following information:

- ☐ Patient's complete demographics, including insurance information
- ☐ A copy of the patient's diagnosis with the appropriate ICD-10 diagnosis code, preferably in the provider's note
- ☐ A copy of the most recent labs and the most recent provider's progress note
- ☐ A copy of the Baptist Cancer Center order sheet with the correct drug selected and the order signed, dated, and timed

- **TB testing:** must be documented at initiation with referrals for abatacept, certolizumab, golimumab, infliximab, risankizumab, secukinumab, tildrakizumab, tocilizumab, and ustekinumab
- **Hepatitis B testing:** must be documented at initiation with referrals for abatacept, certolizumab, golimumab, infliximab, risankizumab, rituximab, tildrakizumab, and tocilizumab.
- **CMP:** send a CMP with new orders and every 12 months during treatment for immune globulin (IVIG) and infliximab
- **Natalizumab (Tysabri):** send signed Patient-Prescriber enrollment form from the TOUCH REMS program at initiation
- **Pegloticase (Krystexxa):** provide a serum uric acid level within 30 days of initiation. Provide documentation of G6PD testing prior to initiation.
- **Tildrakizumab (Ilumya):** provide CMP or liver function tests at initiation and every 6 months. TB testing and Hepatitis B testing must be documented at initiation.

- We will not proceed with prior authorization or scheduling the patient for treatment until all information requested is provided
- Please ensure that we have a valid contact name and number should we need to call for additional information or to clarify orders
- Please note that orders are only valid for 12 months. After that time, new orders and new documentation must be provided.