BIOCARE INFUSION
ONCOLOGY & THERAPEUTICS

NEPHROLOGY ORDER SET

FAX: 470.922.3656 | **PHONE:** 470.377.6400

PATIENT INFORMATION:
Fax completed form, insurance information, and clinical documentation to 470.922.3656

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:**

MEDICAL INFORMATION

Patient Weight: _____ lbs.(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 perio ☐ **Venofer** 200mg IV weekly x 5 dose ☐ **Injectafer** 15mg/kg IV - Give 2 doses at least 7 days apart not to exceed 1500mg (wt <50k ☐ **Injectafer** 750mg IV - Give 2 doses at least 7 days apart not to exceed 1500mg (wt ≥50kg) ☐ **Monoferric** 20mg/kg IV x 1 dose (wt <50kg ☐ **Monoferric** 1000mg IV x 1 dose (wt ≥50kg)	
☐ Chronic Gouty Arthropathy w/tophus (tophi) ☐ Chronic Arthopathy 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: _____ For Biocare Infusion to dispense the methotrexate, please check appropriate box: ☐ Methotrexate 15mg PO weekly x1 year (begin 4 weeks prior to Krystexxa)	**Refills** ☐ _____ ☐ x 1 year
☐ X-linked hypophosphatemia (**ICD-10 Code: E83.31**)	****Max dose 90mg**** **Crysvita** ☐ Adult XLH 1mg/kg subQ rounded to nearest 10mg, every 4 weeks **Crysvita** ☐ Pediatric XLH 0.8 mg/kg subQ rounded to nearest 10mg, q 2 weeks Other dosage: _____, frequency _____	**Refills** ☐ _____ ☐ x 1 year
☐ Diagnosis: _____ (**ICD-10 Code**:_____)	**Rituximab IV** Dose: ☐ 1000mg ☐ 375mg/m2 ☐ Other: _____ Frequency: ☐ One time dose ☐ Weekly x4 weeks ☐ Day 0, repeat dose in 2 weeks ☐ Other: _____ ☐ May substitute biosimilar per insurance. *For Biocare Infusion use* - Brand: _____ ☐ 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 q 4 weeks Other: _____	**Refills** ☐ _____ ☐ x 1 year
☐ Diagnosis: _____ (**ICD-10 Code**:_____)	**IVIg**: ____ mg/kg **OR** ____ gm/kg IV x ____ day(s) **OR** divided over ___ day(s) **Frequency:** Every _____ weeks **OR** _____ (*Biocare Infusion to choose if not indicated*) Preferred brand: _____ Additional Ig orders: _____	**Refills** ☐ _____ ☐ x 1 year

Premedication orders: Tylenol ☐ 1000mg ☐ 500mg PO, please choose one antihistamine:
☐ Diphenhydramine 25-50mg PO/IV ☐ Loratadine 10mg PO ☐ Cetirizine 10mg PO ☐ Quzyttir 10mg IVP
Additional premedications: ☐ Solu-Medrol _____ mg IVP ☐ Solu-Cortef _____ mg IVP ☐ Other _____
Lab orders: _____ **Frequency:** ☐ Every infusion ☐ Other: _____

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing *Biocare Infusion,* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient

Provider Name: _____ Signature: Date: _____

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

☐Opt out of Biocare Infusion selecting site of care (if checked, please list site of care):

PREFERRED LOCATION

City: _____ State: _____ *View our locations here:*

BIOCARE INFUSION
ONCOLOGY & THERAPEUTICS

COMPREHENSIVE SUPPORT FOR NEPHROLOGY THERAPY

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

☐ Include signed and completed order (MD/prescriber to complete page 1)

☐ Include patient demographic information and insurance information

☐ Include patient's medication list

☐ **Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy (attach)**

☐ For biologic orders, has the patient had a documented contraindication/intolerance or failed trial of a conventional therapy (i.e., steroids)? ☐ Yes ☐ No
If yes, which drug(s)? _____

☐ For biologic orders, does the patient have a contraindication/intolerance or failed trial to any other biologic? ☐ Yes ☐ No
If yes, which drug(s)? _____

☐ Include labs and/or test results to support diagnosis

☐ Other medical necessity: _____

REQUIRED INFORMATION

☐ **Baseline serum uric acid & G6PD serum level (Krystexxa**

☐ **CBC, iron, transferrin, ferritin, TIBC (iro**

☐ **Hepatitis B screening test completed. This includes Hepatitis B antigen and Hepatitis B core antibody total (not IgM) (Rituxan)**
☐ Positive ☐ Negative

☐ **Serum phosphorus (Crysvita**

☐ **Nulojix Distribution Program notification (855) 511-6180 - Patient ID# _____**

☐ **TB screening test completed within 12 months (Nulojix)**
☐ Positive ☐ Negative

☐ **EBV serostatus (Nulojix)**

☐ **Creatinine (Ig)**

*If TB or Hep B results are positive - please provide documentation of treatment or medical clearance and a negative CXR (TB)

Biocare Infusion 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 refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (470) 922-3656 or call (470) 377-6400 for assistance