

Patient Information

Patient Name: _____ DOB: _____ Height: _____ Weight: _____ Patient Contact #: _____

Medical Assessment

Diagnosis (ICD-10):

- ☐ D59.3 Atypical Hemolytic Uremic Syndrome (aHUS) ☐ M1A. _____ 0 Chronic gout
☐ D59.5 Paroxysmal Nocturnal Hemoglobinuria (PNH) ☐ M10. _____ Idiopathic gout
☐ Other: _____

****Please include a demographics page, front and back of an insurance card, any clinical notes with supporting diagnosis, lab-work, tests, and any other supporting documentation including past tried and / or failed therapies associated with diagnosis****

Allergies: _____

Pre-Medication Orders:

- ☐ APAP ☐ 325mg ☐ 500mg ☐ 650mg - PO 30 minutes before infusion.
☐ Diphenhydramine ☐ 25mg ☐ 50mg - PO 30 minutes before infusion OR ☐ 25mg IVP ☐ 50mg IVP
☐ Alternate Oral Antihistamines: ☐ Cetirizine 10mg ☐ Loratadine 10mg ☐ Fexofenadine 60mg or ☐ 180mg
☐ Methylprednisolone ☐ 40mg IVP ☐ 125mg IVP or other _____ mg IVP
☐ Famotidine ☐ 20mg PO ☐ 40mg PO ☐ 20mg IVP ☐ 40mg IVP
☐ Ondansetron ☐ 4 mg IVP ☐ 4 mg PO

Labwork: _____ To be Drawn by: ☐ Infusion Clinic ☐ Referring Provider**Medication****Soliris (eculizumab)**

Atypical Hemolytic Uremic Syndrome (aHUS)

- ☐ Induction: 900mg IV at week 0, 1, 2, and 3
☐ Maintenance: 1200mg IV at week 5 and every 2 weeks thereafter

Maintenance Refills: _____

Paroxysmal Nocturnal Hemoglobinuria (PNS)

- ☐ Induction: 600mg IV at week 0, 1, 2, and 3
☐ Maintenance: 900mg IV at week 5 and every 2 weeks thereafter

Maintenance Refills: _____

Rituximab (Rituxan & Biosimilars)☐ Preferred - Infusion Clinic Preference (Rituxan / Ruxience / Truxima) based on payer directives / availability☐ Specific Product: _____

Dosage / Frequency

- ☐ 1000 mg IV at 0 week and 2 weeks every 4 months (16 weeks)
☐ 1000 mg IV at 0 week and 2 weeks every 6 months (24 weeks)
☐ Other orders: _____

Maintenance Refills: _____

**** Pre-medications of acetaminophen PO, diphenhydramine IVP, and methylprednisolone is recommended prior to infusion****

Krystexxa (pegloticase)

- ☐ 8 mg per every 2 weeks

Maintenance Refills: _____

**** Pre-medications of diphenhydramine IVP and methylprednisolone is recommended prior to infusion****

Physician Prescription Orders Address: _____ Phone: _____

Fax: _____ Clinic Contact: _____ Physician Name: _____

NPI # _____ Physician Signature: _____ Date: _____