RELIANT SPECIALTY INFUSION

AIC Nephrology **Fax: 833-808-0833**

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:* _____**