# Lupus
## REFERRAL FORM

**FAX REFERRAL TO:** +1(844) 277-0049 **PHONE:** +1(844) 650-5802

IV Solutions RX

## 1 PATIENT'S INFORMATION *(Complete or include demographic sheet)*

**Patient Name:** _____ **DOB:** _____ **Gender:** ☐ MALE ☐ FEMALE
**Address:** _____ **City/State/Zip:** _____
**Primary Phone:** _____ **Email:** _____ **SSN:** _____ **Primary Language:** _____
**Emergency Contact:** _____ **Relationship to Patient:** _____ **Phone:** _____

## 2 INSURANCE *(Please attach **If Available** a copy of the Patient's' insurance card(s) Front/ Back)*

**Primary Insurance:** _____ **Policy No:** _____ **Group:** _____
**Primary RX Insurance:** _____ **ID No:** _____ **RX GRP:** _____ **RX BIN:** _____ **RX PCN:** _____

## 3 DIAGNOSIS AND CLINICAL INFORMATION

**First time receiving Therapy?** ☐ Yes ☐ No **If No, previous product used:** _____ **Last Dose Given:** _____

**Diagnosis** (ICD-10):

- ☐ M32.1 Systemic lupus erythematosus (SLE)
- ☐ M32.11 Endocarditis in systemic lupus erythematosus
- ☐ M32.12 Pericarditis in systemic lupus erythematosus
- ☐ M32.13 Lung involvement in systemic lupus erythematosus
- ☐ M32.14 Glomerular disease in systemic lupus erythematosus
- ☐ M32.15 Tubulo-interstitial nephropathy in systemic lupus erythematosus
- ☐ M32.19 Other organ or system involvement in systemic lupus erythematosus
- ☐ M32.8 Other forms of systemic lupus erythematosus
- ☐ M32.9 Systemic lupus erythematosus, unspecified
- ☐ Other:_____ Description:_____

**Patient Clinical Information:**

**Drug Allergies:** _____ ☐ NKDA **Ht:** _____in/cm **Wt:** _____lbs/Kg

**Positive ANA or anti-dsDNA test?** ☐ YES ☐ NO

**Labs:** Please fax copy of the following labs dated within 1 year of the patients referral request: ☐ **CMP** ☐ **CBCw/ diff**

## 4 PRESCRIPTION INFORMATION

**ACCESS:** ☐ IV ☐ PORT ☐ SC

**RX INFORMATION:** Our pharmacist will identify clinically appropriate brand *(Unless product is specifically specified at the time of referral)* and infusion rate per FDA guidelines. Clinically appropriate substitutions may be allowed based on availability or payor requirements. Round dose(s) to the nearest vial size. Official orders will be outlined with "May Infuse" +/- 3 days if scheduling needs arises, with insurance payor approval".

**PRODUCT:** ☐ Benlysta (IV) ☐ Benlysta (SC) ☐ SAPHNELO ☐ Other: _____

**DOSE & DIRECTIONS**

**LOADING DOSE:** _____

**MAINTENANCE DOSE:** _____

**PRE/POST ORDERS:**

| MEDICATION | DIRECTION | QUANTITY | REFILLS |
|---|---|---|---|
| ☐ SoluMedrol® **(IV)** | Give _____ mg prior to infusion via ☐ IV push ☐ diluted in _____ mL of NS over 30 min. | Quantity: **Q.S** | Refills: **PRN** |
| ☐ Diphenhydramine: ☐ **PO** ☐ **IV**<br>☐ Loratadine **(PO)** | Administer _____ mg 30-60 min Prior to Infusion. May repeat every _____ hours PRN. | Quantity: **Q.S** | Refills: **PRN** |
| ☐ Acetaminophen **(PO)** | Administer _____ mg PO 30-60 min Prior to Infusion. May repeat every _____ hours PRN. | Quantity: **Q.S** | Refills: **PRN** |

**ANAPHYLAXIS PROTOCOL:**

| MEDICATION | DIRECTION | QUANTITY | REFILLS |
|---|---|---|---|
| ☒ EPINEPHRINE **(vial or autoinjector)** | Administer IM for severe anaphylactic reaction. May repeat in 5-15 minutes<br>☐ ***0.3 mg (Wt > 30 kg)*** ☐ ***0.15 mg (Wt 15-30 kg)*** ☐ ***0.1 mg (Wt 7.5-15 kg)*** | Quantity: **(x1) Vial** or **(x2) Pen(s)** | Refills: **PRN** |
| ☒ DIPHENHYDRAMINE **(50mg/mL )** | Administer via IM or slow IV push for severe anaphylactic reaction.<br>☐ ***50 mg (Wt > 30 kg)*** ☐ ***25 mg (Wt 15-30 kg)*** ☐ ***12.5mg (Wt 7.5-15kg)*** | Quantity: **(x1) Vial(s)** | Refills: **PRN** |
| ☒ SODIUM CHLORIDE 0.9% **(IV)** | Infuse 500 mL IV as directed for severe anaphylactic reaction. | Quantity: **500mL** | Refills: **PRN** |

**NURSING/ LABS/ INFUSION SUPPLIES:**

- ☒ **NURSING:** Nursing visits with each infusion to establish venous access, administer medication, assess and monitor patient, provide education, and complete lab draws.
- ☒ **INFUSION SUPPLIES:** Diluent, infusion supplies, and infusion pump PRN for the reconstitution, administration, and disposal of medication.
- **FLUSHING PROTOCOL:** ☒ Sodium chloride 0.9%, Up to 10 mL before/after medication, and/or PRN to maintain patency.
  Heparin: ☐ 10 Units/mL ☐ 100 Units/mL, _____ as final flush and/or PRN to maintain patency
- ☒ **LABS:** [Dx code: Z79.899] Labs as follows, to be drawn annually by RN prior to infusion unless frequency is specified: every _____ month(s)
  ☐ CMP ☐ CBC w/ diff ☐ Other: _____
- ☒ **LABS:** TB test shall be ordered at a frequency deemed appropriate and performed by an outside lab facility.

## 5 PRESCRIBER INFORMATION

**Prescriber Name:** _____ **Title:** ☐ **MD** ☐ **DO** ☐ **ND** ☐ **PA** ☐ **APRN** **NPI:** _____
**Address:** _____ **City/State/Zip:** _____
**Phone:** _____ **Fax:** _____ **Contact Person:** _____

**The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record.**
I authorize IV Solutions RX and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future refills of the same prescription for the patient listed above. I understand that I can revoke the designation at any time by providing written notice to IV Solutions RX.



**Physicians signature** **Date**

**THANK YOU FOR YOU TRUSTING US IN YOUR PATIENTS SPECIALTY CARE**

#welcome to our family