BrookWell HEALTH

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Please FAX referral form and required clinical and demographic info to:

Fax: 844.309.6361

Rheumatology Order Form

PATIENT INFORMATION

Name_____ DOB_____
Address_____
City_____ State____ Zip_____
Phone _____ Alt. Phone _____
Email _____ Gender ☐M ☐F

PROVIDER INFORMATION

Name_____ NPI_____
Address_____
City_____ State____ Zip_____
Phone_____ Fax_____
Office Contact _____ Phone_____

REQUIRED ✓Insurance Card Front/Back ✓Prescription Insurance Card Front/Back ✓Clinical Notes ✓Lab/Test Results

CLINICAL INFORMATION

ICD-10_____ Diagnosis Description_____
Drug Allergies_____ Latex Allergy ☐Yes ☐No
Height_____ (in) Weight_____(lbs) TB/PPD Test Given: ☐Yes ☐No Hepatitis B Vaccination: ☐Yes ☐No
Line Access ☐PIV ☐Port ☐PICC ☐Midline Initial Infusion: ☐Yes ☐No (If no, date of last infusion_____)

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QTY	REFILLS
☐ **Actemra** (Tocilizumab)	☐ 80mg Vial ☐ 200mg Vial ☐ 400mg Vial ☐ 162mg/0.9ml PFS	☐ **Initial Dose:** Infuse 4mg/kg IV every 4 weeks ☐ **Maintenance Dose:** Infuse 8mg/kg IV every 4 weeks ☐ Inject 162mg SQ ☐ every week ☐ every other week		
☐ **Benlysta** (Belimumab)	☐ 120mg/5ml Vial ☐ 400mg/20ml Vial ☐ 200mg/ml PFS	☐ **Starting Dose:** Infuse 10mg/kg IV every 2 weeks x 3 doses ☐ **Maintenance Dose:** Infuse 10mg/kg IV every 4 weeks ☐ Inject 200mg SQ every week	**3 Doses**	**None**
☐ **Cimzia** (Certolizumab Pegol)	☐ 200mg/ml Vial ☐ 200mg/ml PFS	**Starting Dose:** Inject 400mg SQ at week 0, 2, and 4 ☐ **Maintenance Dose:** Inject 400mg SQ every 4 weeks ☐ **Maintenance Dose:** Inject 200mg SQ every other week	**6 Doses**	**None**
☐ **Orencia** (Abatacept)	☐ 250mg Vial ☐ 50mg/0.4ml PFS ☐ 87.5mg/0.7ml PFS ☐ 125mg/ml PFS	**Starting Dose:** Infuse _____ mg IV at week 0, 2, and 4 ☐ **Maintenance Dose:** Infuse _____mg IV every 4 weeks ☐ **Maintenance Dose:** Inject 125mg SQ every week	**3 Doses**	**None**
☐ **Remicade** (Infliximab)	100mg Vial	PLEASE SEE DRUG SPECIFIC FORM		
☐ **Simponi Aria** (Golimumab)	50mg/4ml Vial	**Starting Dose:** Infuse 2mg/kg IV at week 0 and 4 **Maintenance Dose:** Infuse 2mg/kg every 8 weeks	**2 Doses**	**None**
☐ **Stelara** (Ustekinumab)	☐ 45mg/0.5ml PFS ☐ 90mg/1ml PFS	**Starting Dose:** Inject _____mg SQ at week 0 and 4 **Maintenance Dose:** Inject _____mg SQ every 12 weeks	**2 Doses**	**None**
☐ **Other:**_____	_____	_____		

PRE-MEDICATION	DOSE/STRENGTH	DIRECTIONS
☐ **Acetaminophen**	500mg	Take 1-2 tablets PO prior to infusion or post-infusion as directed
☐ **Cetirizine**	10mg	Take 1 tablet PO prior to infusion or as directed
☐ **Diphenhydramine**	☐ 25mg IV/PO ☐ 50mg IV/PO	Take 1 tablet PO prior to infusion or as directed OR Inject contents of 1 vial IV prior to infusion or as directed
☐ **Methylprednisolone**	☐ 40mg ☐ 125mg	Inject contents of 1 vial IV prior to infusion or as directed
☐ **Ondansetron ODT**	4mg	Take 1-2 tabs prior to infusion or as directed
☐ **Other**	_____	_____

☐ **Adverse Reaction Management Protocol (includes hypersensitivity and allergic / anaphylactic reactions)**

My signature below certifies that (1) The above-named individual is my patient and the therapy identified has been deemed medically necessary. (2) All information provided is true and accurate to the best of my knowledge. (3) I authorize the use of BrookWell Health's Infusion and line access and flushing protocols. (4) I authorize BrookWell Health to perform any necessary emergency and/or anaphylaxis treatment as per BWH protocol.

Provider Name _____ **Provider Signature** _____ **Date** _____

Adverse Reaction Management Protocol

Hypersensitivity reaction including, but not limited to, fever, rash, itching, rigors, sneezing, nausea and vomiting

If reaction occurs:

- If indicated, stop infusion
- Maintain / establish vascular access
- May utilize the following PRN medications as follows:
  - Allergies, hives, itching - Diphenhydramine 25-50mg PO/IV as a single dose, may repeat with either medication if needed
  - Nausea, vomiting, heartburn - Ondansetron 4mg ODT (may repeat in 20 minutes if nausea continues) or Famotidine 20mg PO as a single dose; if severe - give Ondansetron 4mg slow IVP (may repeat in 20 minutes if nausea continues) or Famotidine 20mg slow IVP
  - Headache, pain or fever> 100.4°F - Acetaminophen 500mg 1-2 tablets PO as a single dose or Ibuprofen 400mg PO as a single dose
  - Hypotension (90/60) - place patient in reclined position, administer 0.9% NaCl IV 500ml, may repeat to keep BP > 90/60, monitor vital signs
  - Hypertension (> 30mmHg above baseline or > 180mmHg SBP) - Clonidine 0.1mg and wait 45 minutes, may administer amlodipine 5mg if hypertension persists
  - Chest pain/discomfort or shortness of breath - Oxygen 2-15 liters, titrate to keep SPO2 $\geq$ 92%
  - May give Famotidine 20mg IV or Methylprednisolone 125mg IV - refractory to other treatments given
- May resume infusion when symptoms resolve at 50% previous rate and increase per manufacturer guidelines

Severe allergic/anaphylactic reaction management

- Obtain a thorough allergy and drug history, note any cross-sensitivity
- Identify risk factors for anaphylaxis including history of severe drug reactions and family history of same, when administering blood/blood components and the first dose of an infusion medication.
- Identify and respond to signs/symptoms of anaphylaxis which is the likely type of reaction when all of the following criteria are met:
  - Sudden onset and progression of symptoms
  - Life-threatening airway / breathing / circulatory symptoms, such as laryngeal edema, stridor, severe dyspnea / wheezing, confusion, signs of shock, tachycardia, hypotension, cardiac arrest
  - Skin changes or changes in mucosa, such as flushing urticaria, angioedema
- Symptoms associated with less severe systemic reactions may include
  - Neurological - dizziness, headache, weakness, syncope, seizures
  - Psychiatric - anxiety
  - Respiratory - dyspnea, wheezing, bronchospasm, tachypnea
  - Cardiovascular - tachycardia, hypotension, arrhythmias
  - Cutaneous - flushing erythema, pruritis, urticaria, angioedema
- Interventions
  1) Stop infusion immediately
  2) Discontinue any medication suspected of causing reaction
  3) Initiate basic life support as needed
     - Initiate rapid response team, “Code”
  4) Utilize the ‘Emergency Management of Anaphylaxis’ in the Reaction Management Kit to follow steps for correct management of reaction.
  5) Perform interventions and treatments as ordered or according to organizational protocol
  6) Administer emergency medications - medications will include
     - Epinephrine
     - Corticosteroids - methylprednisolone 40mg or 125mg IV
     - Antihistamines - Diphenhydramine 25 - 50mg IV
     - IV fluids - 0.9% NaCl

     Resuscitation equipment will include
     - Barrier mask for CPR
     - Self-inflating bag for CPR mask

     Breathing support
     - Oxygen and delivery system or device
  7) Monitor patient’s vital signs. Monitor and observe patient for at least 6 hours
  8) Patient may require transfer to ER department for observation period
- Documentation - document in the patient’s health record
  - Presence of allergies/reactions
  - Observations and patient assessment
  - Licensed practitioner notification
  - Interventions taken and outcome
  - Patient condition and response to interventions