BIG SKY IV CARE
Infusion Pharmacy & Nursing
An Access Infusion Care Company

RILONACEPT ORDERS (Arcalyst)

REFERRAL CHECKLIST
Please ensure the following information is included with your referral:
☐ Patient Demographics and Contact Information
☐ Patient Insurance Information
☐ Completed H&P and Progress Notes Including Medications and Allergies
☐ Recent Lab Results/Testing/Screenings Supporting the Diagnosis
☐ Completed and Signed Referral
☐ Recent lab results (CMP, CBCwdiff, CRP, Lipid Panel, Serum Amyloid A)
Including this information will minimize delays with prior authorizations and ensure timely treatment for your patient. Thank you!

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Print, complete, and fax completed form to (406) 752-0443

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PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name:	Prescriber Name:
Address:	NPI:
City, State, Zip:	Address:
Cell: Email:	City, State, Zip:
Ht: Wt: kg Last 4 of SSN: DOB:	Phone: Fax:
Allergies:	Contact Person:

REFERRAL STATUS ☐ **New Referral** ☐ **Continuation Order** ☐ **Dose or Frequency Change**

First dose? ☐ Yes ☐ No - Date of last injection:

DIAGNOSIS

☐ Dx code and description:

REQUIRED DOCUMENTATION ☐ **Signed order** ☐ **Demographics/insurance info** ☐ **H&P/labs/tests/progress notes supporting the Dx**

Prior Therapies:

☐TB Screening: ☐Positive ☐Negative-Date:	☐Labs: CBCwdiff, CBC, Lipid panel, CRP, serum amyloid A

PRESCRIBING INFORMATION

LAB ORDERS

Frequency: Every Labs: ☐CMP ☐CBCwdif ☐Lipid Profile ☐Other:

MEDICATION

Medication	Strength	Dose/Directions		Quantity
☒**Rilonacept (Arcalyst)**	220mg/vial	**Loading dose (max dose 320mg):** ☐ Adult: 320mg x 1 dose ☐ Peds: 4.4mg/kg x 1 dose	**Maintenance Dose (max dose 160mg):** ☐ Adult: 160mg weekly ☐ Peds: 2.2mg/kg weekly	☒# sufficient for dose Refills:
		Inject subcutaneously, max volume=2ml per injection site		

Use current documented weight; round calculated dose to nearest vial size +/- 10% of dose.
If not specified, order will be valid for 1 year from the date of signature.

NURSING INSTRUCTIONS/EMERGENCY MEDICATION

RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines Post-Infusion:Use 50ml0.9%NS to flush residual priming volume	PIV:Flush 3-10mL0.9%NS before/after PICC/Midline/Port:Flush 10mL0.9%NS before/after, then 3mLHeparin 10u/mL(PICC/Midline)/ 5mLHeparin 100u/mL(Port) final

Administer the following medications as needed for infusion-related reactions per company protocol:
Adults>40kg: Diphenhydramine25-50mgPO or IVP(2-5min); Acetaminophen325-650mgPO; Methylprednisolone125mgIVP(≥5min); Epinephrine0.3mgIM/SQ, may repeat×1; 0.9%NS500mL IV over 30-60min, may repeat×1 for hypotension.
Pediatrics/Adults<40kg: Diphenhydramine25mgPO or IVP(2-5min); Acetaminophen325mgPO; Methylprednisolone40mgIVP(≥5min); Epinephrine0.15mg(<30kg)/0.3mg(>30kg)IM/SQ, may repeat×1; 0.9%NS500mL IV over 30-60min, may repeat×1 for hypotension.
Oxygen(AIC/AIS only):1-6L/min via NC/face mask; titrate to maintain SpO_2 95-100%.

Prescriber Signature X: _____ **Date:** _____

☐**Product Substitution Permitted** ☐**Dispense as Written**

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