

BLOOD PRODUCT TRANSFUSION ORDER FORM

PAIRENT MEGRANTON	DATIE	NT INCODMATION		BLOOD	PRODUCT TRANSPUSI	JN ONDER FOI	<u>NIVI</u>			
HT: in WT: kg Birth Sox.() Male () Ferrale Alergies () NRCDA (O/s:					First Name:			MI	DOR:	
Provider Name										
Tax ID #: Fax #: Fax #: Fax				,						
STATEMENT OF MEDICAL NECESSITY Primery Diagnosis: (ICD 10 CODE - DESCRIPTION) Secondary Diagnosis: (ICD 10 CODE - DESCRIPTION) Secondary Diagnosis: (ICD 10 CODE - DESCRIPTION) Secondary Diagnosis: (ICD 10 CODE - DESCRIPTION) PERTINENT MEDICAL HISTORY DOES patient have venous access? YES No 14 yes, what type MEDIPORT PIV PICC LINE OTHER: 1) Is the patient laken Darzalex (dardumumab) within the last 6 morths? O Yes No 3) Has the patient taken Darzalex (dardumumab) within the last 6 morths? O Yes No 4) Has type and cross been drawn? O Yes No 16 f yes, date and time If no, patient instructed to go to hospital lab on date/time OR to be drawn at Infusion Center on arrival. NOTES PRESCRIPTION ORDERS: A) ALL MEDIPORTS / N ACCESS WILL BE ACCESSED AND FLUSHED WITH SAUINE PER HORST IS NOTED BY PROVIDER B) Soom its Bad of 9 9% SODIUM CHLORIDE MAY BE HUNG WITH EACH BLOOD PRODUCT TRANSFUSION C) TUBING WILL BE FLUSHED WITH NO NEW WEEK OF ALL BLOOD PRODUCT TRANSFUSION C) TUBING WILL BE FLUSHED WITH NO NEW WEEK OF ALL BLOOD PRODUCT TRANSFUSION C) TUBING WILL BE FLUSHED WITH NO NEW WEEK OF ALL BLOOD PRODUCT TRANSFUSION C) TUBING WILL BE FLUSHED WITH NO NEW WEEK OF ALL BLOOD PRODUCT TRANSFUSION C) TUBING WILL BE FLUSHED WITH NO NEW WEEK OF ALL BLOOD PRODUCT TRANSFUSION C) TUBING WILL BE FLUSHED WITH NO NEW WEEK OF ALL BLOOD PRODUCT TRANSFUSION C) TUBING WILL BE FLUSHED WITH NO NEW WEEK OF ALL BLOOD PRODUCT TRANSFUSION C) TUBING WILL BE FLUSHED WITH NO NEW WEEK OF ALL BLOOD PRODUCT TRANSFUSION C) TUBING WILL BE FLUSHED WITH NO NEW WEEK OF ALL BLOOD PRODUCT TRANSFUSION C) TUBING WILL BE FLUSHED WITH NO NEW WEEK OF ALL BLOOD PRODUCT TRANSFUSION C) TUBING WILL BE FLUSHED WITH NO NEW WEEK OF ALL BLOOD PRODUCT TRANSFUSION C) TUBING WILL BE FLUSHED WITH NO NEW WEEK OF ALL BLOOD PRODUCT TRANSFUSION C) TUBING WILL BE FLUSHED WITH NO NEW WEEK OF ALL BLOOD PRODUCT TRANSFUSION C) TUBING WILL BE FLUSHED WITH NO NEW WEEK OF ALL BLOOD PRODUCT TRANSFUSION C) TUBING WILL BE FLUSHED WITH NO NEW WEEK OF ALL BLOOD PRODUCT TR	Provide	er Name			Contact Name		Contact Phone	e#		
PRIMEDIA MEDICAL HISTORY Does patient have venous access?	NPI#:			Tax ID #	t <u></u>		Fax #:			
PERTINENT MEDICAL HISTORY Does patient flrave venous access?										
Does patient have venous access?	Primar	y Diagnosis: (ICD 10 CODE	+ DESCRIPTION)		Secondary Dia	agnosis: (ICD 10) CODE + DESCRIPTION)			
1) Is the patient incontinent? O Yes O No 2) Is the patient ambulatory? O Yes O No 3) Has the patient taken Darzalex (daraturmunab) within the last 6 months? O Yes O No 4) Has type and cross been drawn? O Yes O No If Yes, date and time										
3) Has the patient taken Darzalex (daratumumab) within the last 6 months? O Yes O No 4) Has type and cross been drawn? O Yes O No If yes, date and time				-			INE OTHER:			
4) Has type and cross been drawn? O Yes O No If yes, date and time	•	•	,	-	-					
OR	,	•	,				e	9. 11.1		
NOTES: PRESCRIPTION ORDERS: A) ALL MEDIPORTS / IV ACCESS WILL BE ACCESSED AND FLUSHED WITH SALINE PER HOSPITAL PROTOCOL PRN UNLESS OTHERWISE NOTED BY PROVIDER B) 500 ml BAG OF 0.9% SODIUM CHLORIDE MAY BE HUNG WITH EACH BLOOD PRODUCT TRANSFUSION C) TUBING WILL BE FLUSHED WITH 0.9% NS LUNTL TUBING IS PINK TINGED OR CLEAR D) H-H MUST BE COMPLETED WITHIN ONE WEEK OF ALL BLOOD PRODUCT TRANSFUSIONS TYPE, CROSSMATCH, AND TRANSFUSE: LEUK OREDUCED PRADUCT LEUKO REDUCED PRBOS LEUKO REDUCED PRBOS LEUKO REDUCED PRADJATED PLASMA LEUKO REDUCED PRADJATED PLATELETS LEUKO REDUCED IRRADIATED PLATELETS LEUKO REDUCED IRRADIATED PLATELETS PLATELETS TYPE SPECIFIC? O Yes OR ONO Other: NONE NOTES/INSTRUCTIONS/COMMENTS PREMEDS NOTES/INSTRUCTIONS/COMMENTS NOTES/INSTRUCTIONS/COMMENTS DIETARY RESTRICTIONS (If none, please indicate): DIETARY RESTRICTIONS (If none, please indicate): Time Date Time Date Time Date	•	• •		-	ite and time	If no, pa	tient instructed to go to n	ospital lab (on	date/time
PRESCRIPTION ORDERS: A) ALL MEDIPORTS / IV ACCESS WILL BE ACCESSED AND FLUSHED WITH SALINE PER HOSPITAL PROTOCOL PRN UNLESS OTHERWISE NOTED BY PROVIDER B) 500 mL BAG OF 0.9% SODUM CHLORIDE MAY BE HUNG WITH EACH BLOOD PRODUCT TRANSFUSION C) TUBING WILL BE FLUSHED WITH 0.9% NS UNTIL TUBING IS PINK TINGED OR CLEAR D) H-H MUST BE COMPLETED WITHIN ONE WEEK OF ALL BLOOD PRODUCT TRANSFUSIONS TYPE, CROSSMATCH, AND TRANSFUSE: LEUKO REDUCED PLASMA LEUKO REDUCED PRBCS LEUKO REDUCED PRBCS LEUKO REDUCED PRADIATED PRBCS LEUKO REDUCED IRRADIATED PLATELETS LEUKO REDUCED IRRADIATED PLATELETS LEUKO REDUCED IRRADIATED PLATELETS PREMEDS ROOTE NONE NA NA NA NA NA NA BENAPRYL (diphenhydramine)) TYLENOL (acetaminophen) LASIX Other: OXYGEN: DIETARY RESTRICTIONS (If none, please indicate): Time Date Time Date Time Date Time Date										
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SELECT	D) H+H	HMUST BE COMPLETED V	VITHIN ONE WEEK OF ALL	BLOOD PF	RODUCT TRANSFUSIONS	3				
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			ible					· -		
	Cosia	nature (If Required)				Time	Dat	e		
			ible							



STAT REFERRAL

GASTROENTEROLOGY ORDER FORM

HT:	:										
Provider Na				First Name:			MI DOB:				
	in WT: kg	Birth Sex :()	Male () Female	Allergies: () N	NKDA, (Or):						
	ame			Contact Name Con			Contact Phone	e#			
NPI #:			Tax II) #:		Fax	x #:				
Primary Dia	NT OF MEDICAL NECESSIT agnosis: ICD-10 Code plus D IT MEDICAL HISTORY ent have venous access?	lescription:	□ NO If ye	es, what type		☐ PIV ☐ PICC L	INE				
1) TB test	performed? O Yes O No	_									
·											
,	diagnosed with Congestiv			,			O Damiaada	O Cinamani Ania Data			
•	previously treated with Er	•		•		select: O Entyvio C	O Remicade	O Simponi Aria Date:			
э) нер-в а	antigen surface antibody t	test? O res	O No Date: _								
c) DOSES I	DDUCTS WILL BE PREPARI MAY BE ROUNDED TO NEA LAR EQUIVALENT SUBSTI	AREST VIAL SI	ZE WITHIN 10%		D DOSE. WEIGHT	FBASED DOSING TO	REMAIN UNL	ESS WEIGHT CHANGES			
ELECT	DOSING OPTION			DOSE	ROUTE			ATE BELOW)	DURA		
ENTYVIO (MAINTENANCE DOSE) 3 RENFLEXIS (LOADING DOSES)			300 mg IV 0, 2, 6 WEEKS								
			300 mg			ONCE EVERY 8 WE					
				mg / kg	IV	0, 2, 6 WEEKS, THE	0, 2, 6 WEEKS, THEN ONCE EVERY WEEKS				
	RENFLEXIS (MAINTENANG	CE DOSES)		mg / kg	IV	ONCE EVERY	WEEKS				
	OTHER:			mg / kg	IV	ONCE EVERY	WEEKS				
				mg / kg	IV LABS	ONCE EVERY	WEEKS				
PREMEDS ECT	MEDICATION	DOSE	ROUTE	SELECT	LABS LA	ONCE EVERY	WEEKS	WHEN			
PREMEDS ECT NON	MEDICATION NE	DOSE NA	ROUTE NA	SELECT N	LABS LA		WEEKS	NA	FREQ NA		
PREMEDS ECT NON	MEDICATION NE NADRYL			SELECT N	LABS LA		WEEKS	NA () PRIOR () POST			
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STAT REFERRAL

GENERAL IV ORDER FORM

Provider Name	DICAL NECESSITY CD 10 CODE + DESC nous access? DERS DIPORTS / IV ACCES AR EQUIVALENT SI SELECT FROM BEL Perform port flush of Perform IV site care	SES WILL BE FUBSTITUTION IN EVERY	Contact Tax ID #: NO If yes, what typ FLUSHED WITH SALINE MAY APPLY weeks per hospital	Secondary Diagnosis: (IC	Contact Phone # Fax #: CD 10 CODE + DESCRIPTION) PIV	
Primary Diagnosis: (IC Does patient have ver PRESCRIPTION ORE a) ALL MED b) BIOSIMIL PLEASE	DICAL NECESSITY CD 10 CODE + DESC nous access? DERS DIPORTS / IV ACCES LAR EQUIVALENT SI SELECT FROM BEL Perform port flush of Perform IV site care	SES WILL BE FUBSTITUTION FOR Every	Tax ID #: NO If yes, what typ FLUSHED WITH SALINE MAY APPLY weeks per hospital	Secondary Diagnosis: (IC	Fax #:Fax #: ED 10 CODE + DESCRIPTION) PIV	
Primary Diagnosis: (IC Does patient have ver PRESCRIPTION ORE a) ALL MED b) BIOSIMIL PLEASE	DICAL NECESSITY CD 10 CODE + DESC nous access? DERS DIPORTS / IV ACCES AR EQUIVALENT SU SELECT FROM BEL Perform port flush of Perform IV site care	SES WILL BE FUBSTITUTION IN COW: e per hospital	NO If yes, what typ FLUSHED WITH SALINE MAY APPLY weeks per hospital	Secondary Diagnosis: (IC	CD 10 CODE + DESCRIPTION) PIV PICC LINE OTHER:_	
oes patient have ver RESCRIPTION ORE a) ALL MED b) BIOSIMIL PLEASE	DERS DIPORTS / IV ACCES LAR EQUIVALENT SI SELECT FROM BEL Perform port flush of Perform IV site care	SES WILL BE FUBSTITUTION DEVELOPMENT LEVERY	FLUSHED WITH SALINE MAY APPLY weeks per hospital	e ☐ MEDIPORT ☐ P PER HOSPITAL PROTOCC	PIV PICC LINE OTHER:_	
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b) BIOSIMIL PLEASE	AR EQUIVALENT SI SELECT FROM BEL Perform port flush e Perform IV site care	.OW: every e per hospital	MAY APPLYweeks per hospital		OL PRN UNLESS OTHERWISE NOTE	ED BY PROVIDER
<u>PLEASE</u>	SELECT FROM BEL Perform port flush e Perform IV site care	. <u>OW:</u> every e per hospital	_ weeks per hospital	protocol.		
	Perform port flush e Perform IV site care	everye per hospital	·	protocol.		
	Perform port flush e Perform IV site care	everye per hospital	·	protocol.		
	Perform IV site care	e per hospital	·	ρισισσοί.		
	Cathilo Activase 2n	ng IVP per ho	spital protocol.			
		0 1				
OTE: For patients v	with central venous	access, please	select: DISCHAR	GE AFTER LAST DOSE		
DDII	2.4		D005	DOUTE	EDECHENOV	DUDATION
DRUC	3 1		DOSE	ROUTE	FREQUENCY	DURATION
DRUC	3 2		DOSE	ROUTE	FREQUENCY	DURATION
DRUG 3			DOSE	ROUTE	FREQUENCY	DURATION
DRUC	G 4		DOSE	ROUTE	FREQUENCY	DURATION
LABS ELECT BELOW LAB REQUESTED		T	FREQUENCY	NOTES/INSTR	RUCTIONS/OTHER	
	ONE	NA	FREQUENCT			
	BC w/ Diff	11/1				
BN						
CN						
_	JN/CREATININE					
ES						
CF	RP					<u></u>
CF						
Ot	her:					
Ot	her:					
CM BU ES CF	MP JN/CREATININE GR RP PK					
Ot	her:					
Ot	iller:					



HYDRATION ORDER FORM

PATIENT INFOR	MATION						
Last Name:			F	First Name:		MI	DOB:
HT:	in WT: kg Birt	h Sex :() Male () Female All	ergies: () NKDA, (Or):			
NPI #:			Tax ID #:		F	ax #:	
STATEMENT OF	MEDICAL NECESSITY						
Primary Diagnosi	s: (ICD 10 CODE)				Date	e of Diagnosis:	
DEDTINENT ME	DICAL HISTORY						
		7./=a					
Does patient hav	e venous access?	_ YES NO) If yes, wha	t type MEDIPORT	☐ PIV ☐ PICC LIN	NE UOTHER:	
a) ALL	MEDIPORTS/IV ACCESS	WILL BE ACCESS	SED AND FLUS	HED WITH SALINE PER F	IOSPITAL PROTOCOL I	PRN UNLESS OTHERWIS	E NOTED BY PROVIDER
PRESCRIPTION	ORDERS FOR HYDRATI	iON Select	the fluid reque	sted AND the correspond	ling rate helow		
		<u>ON</u> GEIEGE	tile liulu reque		-		
1.) □ NORI	WAL SALINE			2.) □ LACTATE	D RINGERS		
□ 500 mL, IV x				□ 500 mL, IV x			
□ 1000 mL (1 Lit	ter), IV x			□ 1000 mL (1 Lite	r), IV x		
RATE				RATE			
	N OVER 1 HOUR			□ BOLUS - GIVEN	OVER 1 HOUR		
Over 2 hours	@ mL/hour			□ Over 2 hours @	mL/hour		
Over 4 hours	@ mL/hour			□ Over 4 hours @	mL/hour		
□ Other:	mL/hour			□ Other:	mL/hour		
LABS:				NOTES	S/INSTRUCTIONS/COM	MENTS	
LECT BELOW	LAB REQUESTED		FREQUENCY				
	NONE	NONE					
	CBC w/ Diff	() PRIOR ()					
	BMP	() PRIOR ()					
	CMP BUN/CREATININE	() PRIOR ()	*				
	Other:	() PRIOR ()					
	Other:	() PRIOR ()	1 PUST				
Physician's Sigi	nature				Time	Date	
	Be Clear and Legible				0		
Cosignature (If I	Required)				Time	Date	
*Signature Must	Be Clear and Legible					Date	
Fax	completed form, supp	ortina documer	ntation, facesh	neet, and insurance ca	rds to the Outpatien	t Infusion Center at 1 (877) 249-1191.



DATI	ENT INFORMATION		NEUR	OLOG\	ORDER FO	<u>RM</u>		
	PATIENT INFORMATION Last Name:						MI DOR:	
	in WT: kg Birt							
	<u>-</u>							
	der Name							
	t:	Tax ID #	:			Fax #:		
	TEMENT OF MEDICAL NECESSITY					D ((D)		
Prima	ary Diagnosis: ICD 10 + Description:					Date of Di	agnosis:	
	FINENT MEDICAL HISTORY	/50 □ NO //		-DIDO	DT [] DU [
	patient have venous access?	YES NO If yes, what ty	уре ∟ Ш	EDIPO	RI L PIV	PICC LINE OTHER:		
PRES	SCRIPTION ORDERS:							
a) AL	L MEDIPORTS / IV ACCESSES WILL	BE FLUSHED WITH SALINE F	PER HOS	PITAL I	PROTOCOL	PRN UNLESS OTHERWISE NO	OTED BY PROVIDER	
•	L PRODUCTS WILL BE PREPARED						POLICY	
c) PA	TIENTS TAKING OCREVUS: Hep-B	antigen surface antibody tes	st? O Y	es O I	No Date:			
SELECT	MEDICATIO	ON / DOSE		ROUTE	=	FREQUEN		DURATION
	TYSABRI 300 mg Infuse Over 1 Hour			IV		Every 4 We	eeks	12 MONTHS
	*PATIENT WILL BE OBSERVED I	FOR 1 HOUR POST INFUSION	,					
	OCREVUS LOADING DOSES			IV	3(00 mg at 0, 2 weeks, then 600i		
	Infrare array of least 2.5 Herry					• , , ,		
	Infuse over at least 2.5 Hours Requires 0.2 or 0.22 Micron II							
	OCREVUS 600 mg MAINTENANO		IV		Once every 6	months		
	Infuse or at least 2.5 Hours Requires 0.2 or 0.22 Micron II	n_l ine Filter						
	Requires 0.2 or 0.22 mileron in	I-Line I inter						
	SOLU-MEDROL mg			IV				
PREI	MEDS				LABS			
SELECT	MEDICATION BENADRYL	DOSE	ROUTE	E	SELECT	LAB REQUESTED	WHEN () PRIOR () POST	FREQUENCY
	ACETAMINOPHEN					BMP CMP	() PRIOR () POST	
	SOLUMEDROL	<u> </u>				BUN/CREATININE	() PRIOR () POST	
	FAMOTIDINE					JCV ANTIBODY (Patients taking Tysabri)	(X) PRIOR () POST	EVERY 6 MONTHS
	Other:					CRP	() PRIOR () POST	
	Other:					ESR	() PRIOR () POST	
	OXYGEN					Other:		
NOTI	 ES/INSTRUCTIONS/COMMENTS/SPI	 	N OBUED	·S·				
11011	EG/INSTRUCTIONS/COMMENTO/OF	EGII IO BICAND ON IIIICATIO	TORDER					
Dhye	ician's Signature			_		Time	Date	
	ature Must Be Clear and Legible					_ 1 11116	Date	
Cosi	gnature (If Required)					Time	Date	
*Sign	ature Must Be Clear and Legible							



	ENT INFORMATION				I ORDER FORM				
	Name: in WT: kg_Birth Sex :() M								
	der Name :								
	EMENT OF MEDICAL NECESSITY	1 ax 1D #:				rax #:			
	ary Diagnosis: ICD 10 + Description:					Date of	Diagnosis:		
	INENT MEDICAL HISTORY patient have venous access? YES N	O If ves. what type	e ☐ MEDIP	ORT PIV	PICC LINE (OTHER:			
	SCRIPTION ORDERS:	, , , , , , , , , , , , , , , , , , ,							
b) AL c) DC AC d) SU	L MEDIPORTS / IV ACCESSES WILL BE FLUSHE L PRODUCTS WILL BE PREPARED AND ADMINI ISES MAY BE ROUNDED TO NEAREST VIAL WIT FUAL BODY WEIGHT IS LESS BSTITION MAY BE PERMITTED BASED ON AVA FERRED BRAND NAME:	STERED PER STAN I'HIN 10 GRAM(S) O ILABILITY. IF ALTEF	IDARD PHAI F THE PRES	RMACY CONC SCRIBED DOSE	ENTRATIONS AND H	IOSPITAL POL OTOCOL UTIL	ICY	DY WEIGH	HT UNLESS
LECT	DOSE		ROUTE		RATE	REPE	AT EVERY		DURATION
	g / kg		IV						
	Flat Dose: g		IV						
PREM				LABS					
ECT	MEDICATION BENADRYL	DOSE	ROUTE	SELECT	LAB REQUES BMP		WHEN () PRIOR () PO	OST	FREQUENCY
	ACETAMINOPHEN				CMP) PRIOR () PO		
	SOLUMEDROL				BUN/CREATININE	() PRIOR () PO	OST	
	FAMOTIDINE				Other:) PRIOR () PO	OST	
	Other:				Other:		() PRIOR () POST		
NOTE	ES/SPECIAL INSTRUCTIONS	<u>'</u>							
Phys *Sign	sician's Signature ature Must Be Clear and Legible				Time_		1	Date	
Cosi *Sian	gnature (If Required) ature Must Be Clear and Legible				Time_			Date	
- 9"									



OSTEOPOROSIS ORDER FORM

	INFORMATION	_					
	e: First Name:						
HT:	in WT: kg Birth Sex :() Male () Female Allergies: () NKDA, (Or):						
	ame Contact Name						
NPI #:	Tax ID #:		Fax #: _				
	INT OF MEDICAL NECESSITY agnosis: (ICD-10 CODE + DESCRIPTION)		Б.	(0)			
	IT MEDICAL MOTORY		Date o	of Diagnosis:			
	NT MEDICAL HISTORY Inthave venous access? YES NO If yes, what type MEDIPORT PIV	PICC LINE	OTHER:				
	- , , , ,						
a)	BIOSIMILAR EQUIVALENT SUBSTITUTION MAY APPLY						
PRESCRI	PTION ORDERS						
SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY	DURATIO		
	RECLAST (ZOLEDRONIC ACID) ADMINISTER OVER NO LESS THAN 15 MINUTES	5 mg	IV	ONCE EVERY 12 MONTHS	1 Year		
	BUN, CREAT, AND CALCIUM LEVEL WITHIN 30 DAYS OF APPOINTMENT						
	HOLD IF CALCIUM LEVELS < <u>8.5mg/dL</u> or IONIZED CALCIUM LEVEL < <u>4.5mg/dL</u>						
	or IF CRCL < 35 ML/MIN						
	PROLIA (DENOSUMAB)	60 mg	Sub Q	ONCE EVERY 6 MONTHS	1 Year		
	BUN, CREAT, CALCIUM LEVEL WITIN 90 DAYS OF THE APPOINTMENT HOLD IF CALCIUM LEVELS < 8.5mg/dL or IONIZED CALCIUM LEVEL < 4.5mg/dL						
	or IF CRCL < 30 ML/MIN						
	EVENITY	210 mg	Sub Q	ONCE EVERY MONTH x 12	1 Year		
	BUN, CREAT, CALCIUM LEVEL WITIN 90 DAYS OF THE APPOINTMENT						
	HOLD IF CALCIUM LEVELS $<$ <u>8.5 mg/dL</u> or IONIZED CALCIUM LEVEL $<$ <u>4.5 mg/dL</u> or IF CRCL $<$ 30 ML/MIN						
LAB ORD	ERS: Calcium, BUN, Serum Creatinine will be drawn prior to administration is previous resu	ılts not provi	ded within 90	days of appointment.			
SUPPOR	ING DOCUMENTATION FOR PATIENTS RECEIVING RECLAST, PROLIA, OR EVENITY:						
1)	OSTEOPOROSIS						
•	CALCIUM, BUN, AND SERUM CREATININE TO BE CHECKED WITHIN 30 DAYS FOR PATIE	ENTS TAKING	RECLAST (OR 90 DAYS FOR PATIENTS TAK	(ING PROLIA		
•	ORIGINAL BONE DENSITY/DEXA SCAN SUPPORTING THE DIAGNOSIS OF OSTEOPORO	SIS					
•	H+P OR OFFICE NOTES LISTING THE DIAGNOSIS OF OSTEOPOROSIS IN THE PATIENT I	RECORD DATED WITHIN 1 YEAR PRIOR TO APPOINTMENT					
•	PRIOR/CURRENT MEDICATIONS USED TO TREAT THE DIAGNOSIS OF OSTEOPOROSIS	S MUST BE DOCUMENTED IN PATIENT'S MEDICAL RECORD					
	(Examples: Oral calcium, Vitamin D, Bisphosphonates)						
2)	MEN AT HIGH RISK OF FRACTURE RECEIVING ANDROGEN DEPRIVATION THERAPY FO						
3)	TREATMENT TO INCREASE BONE MASS IN WOMEN AT HIGH RISK FOR FRACTURE REC						
*OSTEOF DENISTY	ENIA IS NOT AN APPROVED DIAGNOSIS FOR PROLIA (DENOSUMAB). PATIENTS WITH IMI RESULT OR DEXA SCAN SUPPORTING THE DIAGNOSIS OF OSTEOPOROSIS OR DOCUME	PRESSIONS (ENTATION OF	OF OSTEOPE A PREVIOU	INIA MUST HAVE AN ORIGINAL S FRAGILITY FRACTURE.	BONE		
	SUBMIT DOCUMENTATION OF ANY TRIED AND FAILED ORAL / INJECTIBLE MEDICATIONS BE / FAILURE TO TREATMENT.	S ALONG WIT	TH THE SUPF	PORTING DOCUMENTATION OF	THE PATIENT		
*PROLIA,	RECLAST, AND EVENITY ARE CONTRAINDICATED IN PATIENTS WITH HYPOCALCEMIA.						
*EVENITY	SHOULD NOT BE ADMINISTERED TO PATIENTS WHO HAVE A HISTORY OF STROKE OR I	MI (MYOCARI	DIAL INFARC	TION) WITHIN THE LAST 12 MO	NTHS.		
		me		Date			
*Signature	Must Be Clear and Legible						
		ne		Date			
*Signature	Must Be Clear and Legible						

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.



PATIENT INF		E MARROW STIMULATING AGENTS	S ORDER FORM		
		First Name:		MI	DOB:
HT:	in WT: kg Birth Sex :() Male () Fe	male Allergies: () NKDA, (Or):			
	e				
NPI #:	Та	ax ID #:	Fa	x #:	
STATEMENT	OF MEDICAL NECESSITY Primary Diagnosis: (ICD	-10 Code plus Description)			
Date of Diagno	osis:				
PRESCRIPTION	ON ORDERS				
a) B	IOSIMILAR EQUIVALENT SUBSTITUTION MAY APP	rLY			
Collect CBC	prior to each injection (s) and fax results to:		_		
Hold erythro	poietin injections if Hemoglobin is ≥ to _12 g/d	<u>L</u>			
SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY	DURATION
	Aranesp				
	Neulasta				
	Neupogen				
	Procrit ESRD (Patients on Dialysis)				
	Procrit NON ESRD				
	Retacrit ESRD (Patients on Dialysis)				
	Retacrit NON ESRD				
	Other:				
NOTES:					
				_	
Physician's S *Signature Mu	Signature ust Be Clear and Legible		Time	Date	
Cosignature	(If Required)		Time	Date	
oignature Mu	ist Be Clear and Legible				



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ASTHMA AGENT ORDER FORM

PATIENT	<u>INFORMATION</u>			OILDERI			
	e:						
HT:	in WT: kg Birth Sex :() Ma	le () Female	Allergies: () N	IKDA, (Or):			
	lame						
NPI #:		Tax ID #:			Fax #: _		
	ENT OF MEDICAL NECESSITY agnosis: (ICD-10 Code plus Description)						
	agnosis:						
	PTION ORDERS	OD DUDATION O	- 000-0 INII	-00 WEIOUT	OUANOES / BV 40.0/		
a)	WEIGHT BASED DOSING WILL REMAIN FO	OR DURATION O	F ORDER UNLI	ESS WEIGHT	CHANGES +/- BY 10 %		
b)	Pretreatment Serum IgE (Xolair)			_ units / mL			
SELECT	MEDICATION	DOSE	ROUTE		FREQUEN	CY	DURATION
	XOLAIR	150 m 225 m 300 m 375 m	g g		Every	_ Weeks	
	FASENRA (LOADING DOSES)	30 mg	Sub Q		Every 4 weeks for 3 doses,	then every 8 weeks	
	FASENRA (MAINTANENCE DOSES)	30 mg	Sub Q		Every 8 wee	=	
	NUCALA	100 MG	Sub Q		Every 4 wee	eks	
	TEZSPIRE	210 mg	Sub Q		Every 4 wee	eks	
DDEMED				1.450			
PREMEDS SELECT BELOW	MEDICATION	DOSE	ROUTE	SELECT BELOW	LAB REQUESTED	WHEN	FREQUENC
N	IONE	NA	NA		NONE	NA	NA
E	BENADRYL (diphenhydramine)				BMP	() PRIOR () POST	
	YLENOL (acetaminophen)				CMP	() PRIOR () POST	
	DXYGEN				BUN/CREATININE	() PRIOR () POST	
	Other:				CRP:	() PRIOR () POST	
۲	Other:				ESR:	() PRIOR () POST	
C	Other:				Other:	() PRIOR () POST	
NOTES:							
Physician *Signature	's Signature Must Be Clear and Legible				_Time	Date	
	ure (If Required) Must Be Clear and Legible				_ Time	Date	



STAT REFERRA

RHEUMATOLOGY ORDER FORM

PATIENT INFORMATION		RHEUMATOLOG	OKDER F	<u>UKWI</u>		
		First Name:			MI_ DO	DB:
HT: in WT: kg Birth Sex :() Male						
Provider Name						
NPI #:STATEMENT OF MEDICAL NECESSITY	Tax ID	#:		Fax #:		<u></u> .
Primary Diagnosis: (ICD-10 Code plus Description)						
PERTINENT MEDICAL HISTORY						
Does patient have venous access? YES NO	If ves. what	type MEDIPOR	RT PIV	PICC LINE OTHER:		
1) TB test performed? O Yes O No Date:	-					
2) Hep-B antigen surface antibody test? O Yes O No Date:						
Patient previously treated with any of the following: (please selections)		O Inflectra O Simpo	ni Aria O Ben	lysta O Rituxan O Orencia O Act	temra O Stelara, Date:	
	,	,		,	,	
PRESCRIPTION ORDERS:						
a) ALL MEDIPORTS / IV ACCESSES WILL BE FLUSHED	WITH SALINE	PER HOSPITAL P	ROTOCOL F	PRN UNLESS OTHERWISE NO	TED BY PROVIDER	
b) ALL PRODUCTS WILL BE PREPARED AND ADMINIST	ERED PER S	TANDARD PHARM	IACY CONCE	ENTRATIONS AND HOSPITAL I	POLICY	
c) DOSES MAY BE ROUNDED TO NEAREST VIAL SIZE ${\tt V}$	NITHIN 10% (OF PRESCRIBED D	OSE. WEIG	HT BASED DOSING TO REMA	IN UNLESS WEIGHT CH	IANGES +/- BY %
d) BIOSIMILAR EQUIVALENT SUBSTITUTION MAY APPL	_Y					
MEDICATION MEDICATION		DOSE	ROUTE		UENCY	DURATION
Actemra (Max Dose = 800mg)		mg/kg	IV	Every 4 Weeks		
Benlysta Loading Dose(s)	10 mg / k	g	IV	0, 2, 4 Weeks, Then Once	e Every 4 Weeks	
Benlysta Maintenance Dose	10 mg / k	g	IV	Once Every 4 Weeks		
Krystexxa	8 mg		IV	Once Every 2 Weeks		
Orencia Loading Dose(s)		mg	IV	0, 2, 4 Weeks, Then Once	e Every 4 Weeks	
Orencia Maintenance Dose(s)		mg	IV	Once Every 4 Weeks		
Remicade (infliximab) Loading Dose(s)		mg / kg	IV	0, 2, 6 Weeks, Then Once	e Every Weeks	
Remicade (infliximab) Maintenance Dose(s)	mg / kg		IV	Once Every Weeks		
Rituxan	mg / kg		IV	Once Every Weeks		
Simponi Aria		mg / kg	IV	Once Every Weel	ks	
Stelara Loading Dose(s)		mg	IV	Once		1
*Sub Q administration is NOT covered Outpatient						
PREMEDS			LABS			
ELECT MEDICATION	DOSE	ROUTE	SELECT	LAB REQUESTED	WHEN	FREQUENCY
NONE	NA	NA		NONE	NA	NA
BENADRYL (diphenhydramine)		 		BMP CMP		
TYLENOL (acetaminophen) PEPCID (famotidine)		+ + +		BUN/CREATININE		
SOLU-MEDROL (methylprednisolone)				CRP		
ZOFRAN (ondansetron)				ESR		
Other:				ALT		
Other:				AST		
Other:				LIVER PANEL		
OXYGEN:				OTHER:		
Physician's Signature*Signature Must Be Clear and Legible				Time	Date	_
Cosignature (If Required)*Signature Must Be Clear and Legible				Time	Date	_



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DATIENT	LINEODMATION	<u>!</u>	RON PRODUC	T ORDER FORM	<u>1</u>		
	TINFORMATION ne:		First Name			MI DOE	۹۰
	in WT:kg Birth Sex:(
Provider	Name	C	ontact Name		Contact	Phone #	
STATEM	ENT OF MEDICAL NECESSITY						
Primary [Diagnosis: (ICD-10 Code plus Description)						
						_Date of Diagnosis:	
	ENT MEDICAL HISTORY ient have venous access? YES	NO If yes, what type	e MEDIPOR	T PIV 1	PICC LINE OTHER:		
PRESCR	RIPTION ORDERS						
a)	ALL MEDIPORTS/IV ACCESS WILL BE ACCE	SSED AND FLUSHED WI	TH SALINE PER H	HOSPITAL PROTO	OCOL PRN UNLESS OTHERWIS	E NOTED BY PROVIDER	
b)	ALL PRODUCTS WILL BE PREPARED AND A						
c)	SUPPORTING LABWORK AND DOCUMENTA	TION OF ORAL IRON TR	EATMENT MAY B	E REQUIRED BAS	SED ON INDIVIDUAL PAYOR GU	JIDELINES	
d)	PRODUCT SUBSTITUTION MAY APPLY BAS	ED ON AVAILABILITY OR	INSURANCE REC	QUIREMENTS			
e)	PATIENTS TAKING FERAHEME MUST BE OF	SSERVED FOR 30 MINUT	ES POST INFUSIO	ON. BP AND PULS	SE MUST BE COLLECTED		
ELECT	MEDICATION	DOSE	ROI	UTE	FREG	QUENCY	DURATION
	VENOFER	mg	ľ	V			
	VENOFER	200 mg	IV		ONCE EVERY WEEK		5 Doses
	INJECTAFER	750 mg	lv	IV ONCE E		/ERY WEEK	2 Doses
	INJECTAFER (PATIENT WEIGHT > 50 I	kg) 15 mg / kg	יו	V	ONCE EV	/ERY WEEK	2 Doses
	FERRLECIT	125 mg	l'	V			
	FERRLECIT	250 mg	IV				
	FERAHEME	510 mg	l,	IV ONCE, THEN		AT 3 – 8 DAYS LATER	2 Doses
	OTHER:						
PREMED	os			LABS			
ELECT ELOW	MEDICATION	DOSE	ROUTE	SELECT BELOW	LAB REQUESTED	WHEN	FREQUENC
	NONE	NA	NA		NONE	NA	NA
	BENADRYL (diphenhydramine)	50 mg	IV		ВМР	() PRIOR () POST	
	TYLENOL (acetaminophen)				СМР	() PRIOR () POST	
	EPINEPHRINE	0.3mg / 0.3ml	IM		BUN/CREATININE	() PRIOR () POST	
	SOLU-MEDROL (methylprednisolone)	125 mg	IVP		H+H:	() PRIOR () POST	
	Other:				Ferritin:	() PRIOR () POST	
	OXYGEN:				Other:	() PRIOR () POST	
NOTES:					•	•	
				Tin	ne	Doto	
	n's Signature re Must Be Clear and Legible			ıın	<u></u>	Date	
Cosigna	ture (If Required)			Tin	1e	Date	
⁻ Signatui	re Must Be Clear and Legible						



THERAPEUTIC PHLEBOTOMY ORDER FORM

PATIENT INFO	RMATION						
HT:	_ in WT: kg Bi	rth Sex :() Male () F	emale Allergies: () NI	KDA, (Or):			
					Contact I		
NPI #:		·	Tax ID #:		Fax #:		
STATEMENT C	OF MEDICAL NECESSITY	•					
Primary Diagno	sis: (ICD 10 CODE + DES	CRIPTION)	Seco	ndary Diagnosis: (ICD 10 CODE + DESCRIPTI	ON)	
PRESCRIPTIO	N ORDERS						
b) 10r	L MEDIPORTS / IV ACCES IN NS Flush Syringe PRN IDERS WITH INCOMPLET			OSPITAL PROTOC	COL PRN UNLESS OTHERW	/ISE NOTED BY PRO	VIDER
	ML TO REMOV	VE (+/- 50ML)	PARAMATE	RS	FREQUENCY		DURATION
					1 x only		
herapeutic			HOLD if ≤		Weekly		
hlebotomy			HOLDII		Weekly		
					Monthly		
					Other:		
LABS				NOTES/INS	FRUCTIONS/OTHER		
LECT BELOW	LAB REQUESTED	FREC	QUENCY				
	NONE	NA					
	CBC w/ Diff	PRIOR TO EACH P	HLEBOTOMY				
	Hgb	PRIOR TO EACH P	HLEBOTOMY				
	Hct	PRIOR TO EACH P	HLEBOTOMY				
	ВМР						
	CMP						
	BUN/CREATININE						
	ESR						
	CRP						
	СРК						
	Ferritin						
	Other:						
	Other:						
	•	•		•			
Physician's Si	gnature			Tim	a	Date	
	t Be Clear and Legible				-		
Coolanatura /	f Deguired)			T:		Data	
*Signature Mus	t Be Clear and Legible			Time	;	_ Date	
							1
Fav	completed form sun	norting documentati	on facesheet and in	euranca carde f	o the Outnatient Infusion	n Center at 1 (277	\ 2/Q_11Q1



<u>PATIENT</u>							
	INFORMATION						
	ne:						
ні:	in WT: kg Birth Sex :() I	Male () Female /	Allergies: () NKL	JA, (Or):			
Provider I	Name		Contact Name		Contact	Phone #	
	ENT OF MEDICAL NECESSITY Diagnosis: (ICD-10 Code plus Description)						
, -	g						
				Date of Diagnos	sis:	_	
PERTINE	ENT MEDICAL HISTORY						
	ient have venous access? YES I	NO If yes, what typ	e MEDIPOR	T 🗌 PIV 🔲 I	PICC LINE OTHER:		
	-						
PRESCR	IPTION ORDERS						
LECT	MEDICATION BENADRYL (diphenhydramine)	DOSE	ROU	JTE	FRE	QUENCY	DURA
	COMPAZINE (prochlorperazine)		+				
	DEPACON (valproate)						
	DHE 45 (dihydroergotamine)						
	DILANTIN (phenytoin)						
	KEPPRA (levetiracetam)		+				
	KETOROLAC (Toradol)		_				
	SOLU-MEDROL (methylprednisolone)		-				
	REGLAN (metoclopramide)						
	NORFLEX (orphenadrine)						
	PHENERGAN (promethazine)						
	VYEPTI	100 mg	IV	1	Once Ev	very 3 Months	
	0.9% SODIUM CHLORIDE						
		<u> </u>				-	L
				LABS			
PREMED		DOSE	ROUTE	SELECT	LAB REQUESTED	WHEN	FREQUEN
LECT	MEDICATION	DOSE	ROUTE		LAB REQUESTED	WHEN	FREQUEN
LECT		DOSE	ROUTE	SELECT	LAB REQUESTED NONE	NA	FREQUEN
LECT	MEDICATION			SELECT			
LECT	MEDICATION NONE			SELECT	NONE	NA	
LECT	MEDICATION NONE BENADRYL (diphenhydramine)			SELECT	NONE BMP	NA () PRIOR () POST	
LECT	MEDICATION NONE BENADRYL (diphenhydramine) TYLENOL (acetaminophen)			SELECT	NONE BMP CMP	NA () PRIOR () POST () PRIOR () POST	
LECT	MEDICATION NONE BENADRYL (diphenhydramine) TYLENOL (acetaminophen) ZOFRAN (ondansetron) Other:			SELECT	NONE BMP CMP BUN/CREATININE CRP:	NA () PRIOR () POST	
LECT	MEDICATION NONE BENADRYL (diphenhydramine) TYLENOL (acetaminophen) ZOFRAN (ondansetron)			SELECT	NONE BMP CMP BUN/CREATININE	NA () PRIOR () POST () PRIOR () POST () PRIOR () POST	



ANTIBIOTICS ORDER FORM

PATIENT I Last Name	NFORMATION			Fi	rst Name:			MI	DOB:		
HT:in WT:kg Birth Sex:() Male () Female Allergies:										_	
											_
											_
RIMARY	DIAGNOSIS:				SE(CONDARY DIA	GNOSIS:				
I CC LINE I a)	NSTRUCTIONS M ALL MEDIPORTS/	IUST BE SE	YES NO I ELECTED (Check the SES MAY BE FLUSHEI L FOLLOW AND ADJU	option): [][DISCHARGE PICC AI PER HOSPITAL PRO	FTER LAST DOS OTOCOL PRN L	E LINE UNLESS OTHERW	CARE PER HOS	PITAL PROTOCOL PROVIDER		
SELECT	DRUG	DOSE	ROUTE	REPEAT EVERY	DURATION	SELECT	DRUG	DOSE	ROUTE	REPEAT EVERY	DURATIO
	Vancomycin	500 mg	IV				Invanz (Ertapenem)	1000 mg	() IV () IM		
	Vancomycin	750 mg	IV				Merrem (Meropenem)	500 mg	() IV		
	Vancomycin	1000 mc					Merrem (Meropenem)	1000 mg	() IV		
	Vancomycin	1500 mc	a IV				Gentamicin (Garamycin)		() IV		
	Vancomycin	1750 mc					Gentamicin (Garamycin)	7mg/kg	() IV		
	Vancomycin	2000 mg					Levaquin (Levofloxacin)	250 mg	IV		
	Rocephin (Ceftriaxone)	250 mg					Levaquin (Levofloxacin)	500 mg	IV		
	Rocephin (Ceftriaxone)	500 mg					Levaquin (Levofloxacin)	750 mg	IV		
	Rocephin (Ceftriaxone)	750 mg				1	Dalvance (Dalbavancin)	1500 mg	IV	NA	X 1 Dose
	Rocephin (Ceftriaxone)	1000 mg					Dalvance (Dalbavancin)	1000 mg Day 1 500mg Day 8		INA	X I Dose
	Rocephin (Ceftriaxone)	2000 mg					Orbactiv	1200 mg	IV		
	Invanz (Ertapenem)	500 mg	, , , , ,			1	(Oritavancin) Other:	1200 Hig	IV		
., , .		1 300 mg	() ()			<u> </u>	Other.				
ther (not		PTED.	WILL	FDF	OUENOV	OFI FOT	LAB BEOL	IECTED.	WILL		OUTNOV
SELECT	LAB REQUES	סובט	WHEN NA	FK	NA NA	SELECT	CK LAB REQU	DESTED	WHEN PRIOR() POST()	FRE	QUENCY
	ВМР		PRIOR() POST()				UA		PRIOR() POST()		
			PRIOR() POST()	()			Other:		PRIOR() POST()		
	BUN/CREATININ	NE	PRIOR() POST())			Other:		PRIOR() POST()		
	CRP		PRIOR() POST())			Other:		PRIOR() POST()		
	ESR		PRIOR() POST()				Other:		PRIOR() POST()		
	ALT VANCO TROUG	ш	PRIOR ()				Other:				
	GENT TROUGH						Other:				
NOT	ES:	ı		L							
	sician's Signature		via.			Tim	e	Dat	e		
ŭ	nature must be clea	· ·	ne								
	Signature (If Requ inature must be clea		le			Tim	ie	Dat	e		
	F	1-416	n augustina daar							10 4404	



STAT REFERRAL

LEQEMBI ORDER FORM

PATIENT INFORMATION				
Last Name:				MIDOB:
HT: in WT:	_ kg Birth Sex :() Male	() Female Allergies: () NKDA, (Or):		
Provider Name		Contact Name	Contact Phone	 e#
		Tax ID #:		
Does patient have venous access		O If yes, what type MEDIPORT		
a) ALL MEDIPORTS / IV		USHED WITH SALINE PER HOSPITAL PRO		
,				
PLEASE SELECT FI	ROM BELOW: flush every wee	ks ner hospital protocol		
Perform IV si	te care per hospital protoco			
Activase 2mg	IVP per hospital protocol.			
DUAL DIAGNOSIS IS REQUIRE	O - SELECT ONE OPTION	OF BOTH CONDITIONS THAT APPLY FR	OM BELOW:	
□ G30.0 Alzheimer's Disease,	Early Onset	□ F02.80 Deme	ntia without behavioral disturbance	
□ G30.1 Alzheimer's Disease,	Late Onset ← G3		ntia with behavioral disturbance	
 □ G30.8 Other Alzheimer's dis □ G30.9 Alzheimer's disease, 		dary F02.8X code →		
□ G31.84 Mild Cognitive Impa	irment, So Stated			
□ Other:		(ICD 10 + Descr	iption)	
Prescriber must indicate	the following require	ements have been met (please pro	ovide documentation):	
□ Beta Amyloid Pathology Co	nfirmed Via			
□ Amyloid PET Scan Date:_		OR	Date:Result:	
•		·	Date:Result:	
•		Result: Homozygote [
- Apol 24 Genetic Test Date	•	Nesuit. La Homozygote t	Noncame	
PRESCRIPTION ORDERS	40	D/ O At It CO Mit	F 0 M/s slee	40 Manda
Leqembi	10 mg/kg	IV Over At Least 60 Minutes	Every 2 Weeks (at least 14 days apart)	12 Months
DRUG	DOSE	ROUTE	FREQUENCY	DURATION
Pre-Infusion:				
☑ Confirm basel	ine MRI results prior t	o initiation of treatment.		
	•	ed by prescriber prior to the 5th, 7th	, and 14th treatment.	
✓ Measure and	record weight prior to	each treatment to determine dose.		
☑ Hold infusior	and notify provide	if patient reports:		
 Headad 	che.			
 Dizzine 				
Nausea				
	changes.			
• New or	worsening confusion			
Post-Infusion:				
☑ Educate pati	ent/caregiver to repor	t headache, dizziness, nausea, visio	on changes, or new/worsening o	confusion.
•			Time Date	
*Signature Must Be Clear and Leg			_ Dat	,
Cosignature (If Required)			Time Date	e
*Signature Must Be Clear and Leg	gible			



			Eirot Nom			
				٥.	MI DOI).
		() Male () Female			MI DOI	
	11 Ng Biran cox .	.() Maic () i cinaic	Allergies. () NRDA, (OI).		
Provider Name			Contact Nar	me	Contact Phone #	
					Fax #:	
STATEMENT OF ME						
	CD 10 CODE + DESCRIPTION	JNI)	c	Secondary Diagnosis: (ICD 10 COD	DE + DESCRIPTION)	
Timary Diagnosis. (I	OD 10 OODE 1 DECOMI TH	S(4)		occordary Diagnosis. (IOD TO OOL	DE DECORIT HON	
Does patient have ve	nous access? YES	NO If yes,	what type		CC LINE OTHER:	-
PRESCRIPTION OR		, NO ii yes,	what type _		OO LINE OTHER.	
a) ALL MEI	DIPORTS / IV ACCESSES W	ILL BE FLUSHED WITH	H SALINE PER	R HOSPITAL PROTOCOL PRN UN	NLESS OTHERWISE NOTED BY PROVID	ER
SELECT	MEDICATION	DO	SE	ROUTE	FREQUENCY	DURATION
COSYNI	ROPIN 250 MCG/2ML (NS)	2 ML		IV Push over 2 minutes	ONCE	1
LADO				NOTEO//NOTENOTION	NOTHER	
SELECT BELOW	LAB REQUESTED	FREQUE	NCY	NOTES/INSTRUCTIONS	S/OTHER	
X	ACTH LEVEL	PRIOR				
X	CORTISOL LEVEL	PRIOR AND REPEA	T 30 + 60			
		MINUTES POST INF				
	Other:					
	Other:					
	Other:					
	Other:					
SBP > 1	ns will be measured prior to 80, DBP > 110, or pulse > 12 ne with 10mL 0.9% NS then	20	at completior	n or test, and with any clinical cha	anges that occur during the test. Notify	pnysician ir
Physician's Signatur *Signature Must Be C Cosignature (If Req *Signature Must Be C	Clear and Legible			Time	Date Date	



STAT	REFERRAL
3171	ILLI LIVIVAL

LEQVIO ORDER FORM

	NFORMATION .		ŗ	First Name		MI DOB:_	
						WII DOD	
Dec de Ne			2-	ata d Mana		Ocatast Phase #	
						Contact Phone # Fax #:	
			Tax ID #			rax #	
	IT OF MEDICAL NECESSITY	=		0	D'	E DECORIDATION!	
Primary Dia	gnosis: (ICD 10 CODE + DES	CRIPTION)		Secondary I	Diagnosis: (ICD 10 COD	E + DESCRIPTION)	
Does patier	t have venous access?	YES	NO If yes, wha	t type MEDIPC	ORT PIV PI	CC LINE OTHER:	
PRESCRIP	TION ORDERS						
a)	ALL MEDIPORTS / IV ACCE					ILESS OTHERWISE NOTED BY PROVIDER	
b)	ALL PRODUCTS WILL BE P	REPARED AND A	ADMINISTERED PE	ER STANDARD PHA	RMACY CONCENTRA	TIONS AND HOSPITAL POLICY	
LECT	MEDICATIO		DOSE	ROUTE		FREQUENCY	DURATION
	LEQVIO (LOADING	•	284 mg	SQ		nd 3, then every 6 months	
	LEQVIO (MAINTANEN	CE DOSES)	284 mg	SQ		Every 6 months	
LABS							
LECT BELO	DW LAB REQUESTED		FREQUENCY				
1)	NG DOCUMENTATION FOR SUPPORTING CLINICAL NO CONVENTIONAL THERAPY	OTES TO INCLUE		ED AND/OR FAILED) THERAPIES, INTOLE	RANCE, BENEFITS, OR CONTRAINDICATI	ONS TO
2)	HETEROZYGOUS FAMILIA AGE)? □ YES □ NO	L HYPERCHOLE	STEROLEMIA (HE	FH) - DOES THE PA	ATIENT HAVE A UNTRE	EATED LDL ≥ 190MG/DL (≥ 155MG/DL IF <	16 YEARS OF
3)	☐ FAMILY HIST	OF TENDON XAN TORY OF MI AT <	NTHOMA(S) IN THE <60 YEARS OLD IN CHOLESTEROL >	E PATIENT OR 1ST/ I 1ST DEGREE REL	2ND DEGREE RELATIV	OLD IN 2 ND DEGREE RELATIVE	
4)	ASCVD - DOES THE PATIE	NT'S LDL REMAI	IN ≥ 100MG/DL DE	SPITE TREATMEN	T WITH A HIGH-INTENS	SITY STATIN? YES NO	
5)	HAS THE PATIENT TRIED	AND FAILED PCS	SK9 INHIBITOR AF	TER 12 WEEKS OF	USE? □ YES □ NO		
6)	HAS THE PATIENT TRIED	AND FAILED A H	IGH INTENSITY ST	TATIN FOR ≥ 8 CON	ITINUOUS WEEKS?	YES I NO	
7)	☐ CORONARY	ONARY SYNDRO	OME ERIAL REVASCUL		OSCLEROTIC ORIGIN	☐ HISTORY OF MYOCARDIAL INFARCTI ☐ TRANSIENT ISCHEMIC ATTACK ☐ STROKE	ION
8)	INCLUDE LABS AND/OR TI	ired)	O SUPPORT DIAG R PCSK9 GENE (If				
9)	OTHER MEDICAL NECESS	ITY:					
Physician's	s Signature				Time	Date	
*Signature	s Signature Must Be Clear and Legible						
Cosignatur	re (If Required) Must Be Clear and Legible				Time	Date	
oiyilalul e l	viusi De Oleai aliu Leyible						