SEMINOLE HOSPITAL DISTRICT
INFUSION CENTER
Phone: 432-758-4716 Fax: 877-249-1191

☐ **STAT REFERRAL**

# BLOOD PRODUCT TRANSFUSION ORDER FORM

## PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____ DOB:_____

HT: _____ in WT: _____ kg Birth Sex :( ) Male ( ) Female Allergies: ( ) NKDA, (Or):_____

_____

Provider Name_____ Contact Name _____ Contact Phone # _____

NPI #:_____ Tax ID #:_____ Fax #: _____

## STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD 10 CODE + DESCRIPTION)

_____

Secondary Diagnosis: (ICD 10 CODE + DESCRIPTION)

_____

## PERTINENT MEDICAL HISTORY

Does patient have venous access? ☐ **YES** ☐ **NO** **If yes, what type** ☐ **MEDIPORT** ☐ **PIV** ☐ **PICC LINE** ☐ **OTHER:**_____

1) Is the patient incontinent? O Yes O No 2) Is the patient ambulatory? O Yes O No

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 _____. 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 / 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 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:**

| SELECT | # of UNITS | PRODUCT |
|---|---|---|
| | | FRESH FROZEN PLASMA |
| | | LEUKO REDUCED PRBCs |
| | | LEUKO REDUCED IRRADIATED PRBCs |
| | | LEUKO REDUCED PLATELETS |
| | | LEUKO REDUCED IRRADIATED PLATELETS |
| | | PLATELETS TYPE SPECIFIC? O Yes OR O No |
| | | Other: |

**LABS**

| SELECT | LAB REQUESTED | WHEN |
|---|---|---|
| | NONE | NA |
| | BMP | ( ) PRIOR ( ) POST |
| | CMP | ( ) PRIOR ( ) POST |
| | CBC w/ DIFF | ( ) PRIOR ( ) POST |
| | H+H: | ( ) PRIOR ( ) POST |
| | T+C: | ( ) PRIOR ( ) POST |
| | Other: | ( ) PRIOR ( ) POST |

**PREMEDS**

| SELECT | MEDICATION | DOSE | ROUTE | FREQUENCY |
|---|---|---|---|---|
| | NONE | NA | NA | NA |
| | BENADRYL (diphenhydramine)) | | | |
| | TYLENOL (acetaminophen) | | | |
| | LASIX | | | |
| | Other: | | | |
| | OXYGEN: | | | |

**NOTES/INSTRUCTIONS/COMMENTS**

_____

_____

_____

_____

_____

_____

**DIETARY RESTRICTIONS (If none, please indicate):** _____

**Physician's Signature** _____ **Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

**Cosignature (If Required)**_____ **Time**_____ **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.**

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## GASTROENTEROLOGY ORDER FORM

**PATIENT INFORMATION**

Last Name: _____ First Name: _____ MI_____ DOB:_____

HT: _____ in WT: _____ kg Birth Sex :( ) Male ( ) Female Allergies: ( ) NKDA, (Or):_____

_____

Provider Name_____ Contact Name _____ Contact Phone # _____

NPI #:_____ Tax ID #:_____ Fax #: _____

**STATEMENT OF MEDICAL NECESSITY**

Primary Diagnosis: ICD-10 Code plus Description:_____

**PERTINENT MEDICAL HISTORY**

Does patient have venous access? ☐ **YES** ☐ **NO If yes, what type** ☐ **MEDIPORT** ☐ **PIV** ☐ **PICC LINE**
☐ **OTHER:**_____

1) TB test performed? O Yes O No Date:_____ Results,_____

2) Patient diagnosed with Congestive Heart Failure? O Yes O No 3) Liver function test normal? O Yes O No

4) Patient previously treated with Entyvio OR Remicade OR Simponi Aria? O Yes O No Please select: O Entyvio O Remicade O Simponi Aria Date: _____

5) Hep-B antigen surface antibody test? O Yes O No Date: _____

**PRESCRIPTION ORDERS:**

a) ALL MEDIPORTS / IV ACCESSES WILL BE FLUSHED WITH SALINE PER HOSPITAL PROTOCOL PRN UNLESS OTHERWISE NOTED BY PROVIDER

b) ALL PRODUCTS WILL BE PREPARED AND ADMINISTERED PER STANDARD PHARMACY CONCENTRATIONS AND HOSPITAL POLICY

c) DOSES MAY BE ROUNDED TO NEAREST VIAL SIZE WITHIN 10% OF PRESCRIBED DOSE. WEIGHT BASED DOSING TO REMAIN UNLESS WEIGHT CHANGES +/- BY____ %

d) BIOSIMILAR EQUIVALENT SUBSTITUTION MAY APPLY

| SELECT | DOSING OPTIONS | DOSE | ROUTE | FREQUENCY (POPULATE BELOW) | DURATION |
|---|---|---|---|---|---|
| | ENTYVIO (LOADING DOSES) | 300 mg | IV | 0, 2, 6 WEEKS, THEN ONCE EVERY 8 WEEKS | |
| | ENTYVIO (MAINTENANCE DOSE) | 300 mg | IV | ONCE EVERY 8 WEEKS | |
| | RENFLEXIS (LOADING DOSES) | mg / kg | IV | 0, 2, 6 WEEKS, THEN ONCE EVERY _____ WEEKS | |
| | RENFLEXIS (MAINTENANCE DOSES) | mg / kg | IV | ONCE EVERY WEEKS | |
| | OTHER: | mg / kg | IV | ONCE EVERY WEEKS | |

**PREMEDS**

| SELECT | MEDICATION | DOSE | ROUTE |
|---|---|---|---|
| | NONE | NA | NA |
| | BENADRYL | | |
| | ACETAMINOPHEN | | |
| | SOLU-MEDROL | | |
| | Other: | | |
| | Other: | | |
| | Other: | | |
| | Other: | | |
| | Other: | | |
| | Other: | | |
| | OXYGEN: | | |

**LABS**

| SELECT | LAB REQUESTED | WHEN | FREQUENCY |
|---|---|---|---|
| | NONE | NA | NA |
| | BMP | ( ) PRIOR ( ) POST | |
| | CMP | ( ) PRIOR ( ) POST | |
| | BUN/CREATININE | ( ) PRIOR ( ) POST | |
| | CRP | ( ) PRIOR ( ) POST | |
| | ESR | ( ) PRIOR ( ) POST | |
| | ALT | ( ) PRIOR ( ) POST | |
| | AST | ( ) PRIOR ( ) POST | |
| | LIVER PANEL | ( ) PRIOR ( ) POST | |
| | VECTRA | ( ) PRIOR ( ) POST | |
| | OTHER: | ( ) PRIOR ( ) POST | |

**NOTES/INSTRUCTIONS/COMMENTS**

_____

_____

_____

**Physician's Signature** _____ **Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

**Cosignature (If Required)**_____ **Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

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# GENERAL IV ORDER FORM

## PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____ DOB:_____

HT: _____ in WT: _____ kg Birth Sex :( ) Male ( ) Female Allergies: ( ) NKDA, (Or):_____

_____

Provider Name_____ Contact Name _____ Contact Phone # _____

NPI #:_____ Tax ID #:_____ Fax #: _____

## STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD 10 CODE + DESCRIPTION)

_____

Secondary Diagnosis: (ICD 10 CODE + DESCRIPTION)

_____

Does patient have venous access? ☐ **YES** ☐ **NO** **If yes, what type** ☐ **MEDIPORT** ☐ **PIV** ☐ **PICC LINE** ☐ **OTHER:**_____

## PRESCRIPTION ORDERS

a) ALL MEDIPORTS / IV ACCESSES WILL BE FLUSHED WITH SALINE PER HOSPITAL PROTOCOL PRN UNLESS OTHERWISE NOTED BY PROVIDER

b) BIOSIMILAR EQUIVALENT SUBSTITUTION MAY APPLY

***PLEASE SELECT FROM BELOW:***

_____ Perform port flush every _____ weeks per hospital protocol.

_____ Perform IV site care per hospital protocol.

_____ Cathflo Activase 2mg IVP per hospital protocol.

**NOTE: For patients with central venous access, please select:** ☐ **DISCHARGE AFTER LAST DOSE**

| | | | | |
|---|---|---|---|---|
| | | | | |
| **DRUG 1** | **DOSE** | **ROUTE** | **FREQUENCY** | **DURATION** |
| | | | | |
| **DRUG 2** | **DOSE** | **ROUTE** | **FREQUENCY** | **DURATION** |
| | | | | |
| **DRUG 3** | **DOSE** | **ROUTE** | **FREQUENCY** | **DURATION** |
| | | | | |
| **DRUG 4** | **DOSE** | **ROUTE** | **FREQUENCY** | **DURATION** |

**LABS**

| SELECT BELOW | LAB REQUESTED | FREQUENCY |
|---|---|---|
| | **NONE** | **NA** |
| | **CBC w/ Diff** | |
| | **BMP** | |
| | **CMP** | |
| | **BUN/CREATININE** | |
| | **ESR** | |
| | **CRP** | |
| | **CPK** | |
| | **Other:** | |
| | **Other:** | |

**NOTES/INSTRUCTIONS/OTHER**

_____
_____
_____
_____
_____
_____
_____
_____

**Physician's Signature** _____ **Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

**Cosignature (If Required)**_____ **Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

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☐ **STAT REFERRAL**

# HYDRATION ORDER FORM

## PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____ DOB:_____

HT: _____ in WT: _____ kg Birth Sex :( ) Male ( ) Female Allergies: ( ) NKDA, (Or):_____

_____

Provider Name_____ Contact Name _____ Contact Phone # _____

NPI #:_____ Tax ID #:_____ Fax #: _____

## STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD 10 CODE) _____ Date of Diagnosis: _____

## PERTINENT MEDICAL HISTORY

Does patient have venous access? ☐ **YES** ☐ **NO** **If yes, what type** ☐ **MEDIPORT** ☐ **PIV** ☐ **PICC LINE** ☐ **OTHER:**_____

a) ALL MEDIPORTS/IV ACCESS WILL BE ACCESSED AND FLUSHED WITH SALINE PER HOSPITAL PROTOCOL PRN UNLESS OTHERWISE NOTED BY PROVIDER

## PRESCRIPTION ORDERS FOR HYDRATION

**Select the fluid requested AND the corresponding rate below**

| **1.) ☐ NORMAL SALINE** | **2.) ☐ LACTATED RINGERS** |
|---|---|
| **☐ 500 mL, IV x** | **☐ 500 mL, IV x** |
| **☐ 1000 mL (1 Liter), IV x** | **☐ 1000 mL (1 Liter), IV x** |
| **RATE** | **RATE** |
| **☐ BOLUS - GIVEN 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** |

**☐ ADDITIVES: ○ _____ MEQ K+ ○ _____GM MAG PIGGY BACK ○ OTHER:_____ RATE MAY BE ADJUSTED PER HOSPITAL POLICY**

**(K+ max rate of 10mEq/hr)**

**OTHER (PLEASE SPECIFY DRUG, RATE, FREQUENCY, AND DURATION BELOW:**

_____

**LABS:**

| SELECT BELOW | LAB REQUESTED | FREQUENCY |
|---|---|---|
| | **NONE** | **NONE** |
| | **CBC w/ Diff** | **( ) PRIOR ( ) POST** |
| | **BMP** | **( ) PRIOR ( ) POST** |
| | **CMP** | **( ) PRIOR ( ) POST** |
| | **BUN/CREATININE** | **( ) PRIOR ( ) POST** |
| | **Other:** | **( ) PRIOR ( ) POST** |

**NOTES/INSTRUCTIONS/COMMENTS**

_____

_____

_____

_____

_____

**Physician's Signature** _____ **Time**_____ **Date**_____

**Signature Must Be Clear and Legible*

**Cosignature (If Required)**_____ **Time**_____ **Date**_____

**Signature Must Be Clear and Legible*

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## NEUROLOGY ORDER FORM

**PATIENT INFORMATION**

Last Name: _____ First Name: _____ MI_____ DOB:_____

HT: _____ in WT: _____ kg Birth Sex :( ) Male ( ) Female Allergies: ( ) NKDA, (Or):_____

_____

Provider Name_____ Contact Name _____ Contact Phone # _____

NPI #:_____ Tax ID #:_____ Fax #: _____

**STATEMENT OF MEDICAL NECESSITY**

Primary Diagnosis: ICD 10 + Description:_____ Date of Diagnosis:_____

**PERTINENT MEDICAL HISTORY**

Does patient have venous access? ☐ **YES** ☐ **NO** **If yes, what type** ☐ **MEDIPORT** ☐ **PIV** ☐ **PICC LINE** ☐ **OTHER:**_____

**PRESCRIPTION ORDERS:**

a) ALL MEDIPORTS / IV ACCESSES WILL BE FLUSHED WITH SALINE PER HOSPITAL PROTOCOL PRN UNLESS OTHERWISE NOTED BY PROVIDER

b) ALL PRODUCTS WILL BE PREPARED AND ADMINISTERED PER STANDARD PHARMACY CONCENTRATIONS AND HOSPITAL POLICY

c) PATIENTS TAKING OCREVUS: Hep-B antigen surface antibody test? ○ Yes ○ No Date: _____

| SELECT | MEDICATION / DOSE | ROUTE | FREQUENCY | DURATION |
|---|---|---|---|---|
| | **TYSABRI 300 mg**<br>**Infuse Over 1 Hour**<br>***PATIENT WILL BE OBSERVED FOR 1 HOUR POST INFUSION*** | **IV** | **Every 4 Weeks** | **12 MONTHS** |
| | **OCREVUS LOADING DOSES**<br><br>**Infuse over at least 2.5 Hours**<br>**Requires 0.2 or 0.22 Micron In-Line Filter** | **IV** | **300 mg at 0, 2 weeks, then 600mg once every 6 months** | |
| | **OCREVUS 600 mg MAINTENANCE DOSES**<br><br>**Infuse or at least 2.5 Hours**<br>**Requires 0.2 or 0.22 Micron In-Line Filter** | **IV** | **Once every 6 months** | |
| | **SOLU-MEDROL mg** | **IV** | | |

**PREMEDS**

| SELECT | MEDICATION | DOSE | ROUTE |
|---|---|---|---|
| | **BENADRYL** | | |
| | **ACETAMINOPHEN** | | |
| | **SOLUMEDROL** | | |
| | **FAMOTIDINE** | | |
| | **Other:** | | |
| | **Other:** | | |
| | **OXYGEN** | | |

**LABS**

| SELECT | LAB REQUESTED | WHEN | FREQUENCY |
|---|---|---|---|
| | **BMP** | **( ) PRIOR ( ) POST** | |
| | **CMP** | **( ) PRIOR ( ) POST** | |
| | **BUN/CREATININE** | **( ) PRIOR ( ) POST** | |
| | **JCV ANTIBODY**<br>**(Patients taking Tysabri)** | **(X ) PRIOR ( ) POST** | **EVERY 6 MONTHS** |
| | **CRP** | **( ) PRIOR ( ) POST** | |
| | **ESR** | **( ) PRIOR ( ) POST** | |
| | **Other:** | | |

**NOTES/INSTRUCTIONS/COMMENTS/SPECIFIC BRAND OR TITRATION ORDERS:**

**Physician's Signature** _____ **Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

**Cosignature (If Required)**_____ **Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

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☐ **STAT REFERRAL**

# INTRAVENOUS IMMUNOGLOBULIN ORDER FORM

**PATIENT INFORMATION**

Last Name: _____ First Name: _____ MI_____ DOB:_____

HT: _____ in WT: _____ kg Birth Sex :( ) Male ( ) Female Allergies: ( ) NKDA, (Or):_____

_____

Provider Name_____ Contact Name _____ Contact Phone # _____

NPI #:_____ Tax ID #:_____ Fax #: _____

**STATEMENT OF MEDICAL NECESSITY**

Primary Diagnosis: ICD 10 + Description:_____ Date of Diagnosis:_____

**PERTINENT MEDICAL HISTORY**

Does patient have venous access? ☐ **YES** ☐ **NO** **If yes, what type** ☐ **MEDIPORT** ☐ **PIV** ☐ **PICC LINE** ☐ **OTHER:**_____

**PRESCRIPTION ORDERS:**

a) ALL MEDIPORTS / IV ACCESSES WILL BE FLUSHED WITH SALINE PER HOSPITAL PROTOCOL PRN UNLESS OTHERWISE NOTED BY PROVIDER

b) ALL PRODUCTS WILL BE PREPARED AND ADMINISTERED PER STANDARD PHARMACY CONCENTRATIONS AND HOSPITAL POLICY

c) DOSES MAY BE ROUNDED TO NEAREST VIAL WITHIN 10 GRAM(S) OF THE PRESCRIBED DOSE PER HOSPITAL PROTOCOL UTILIZING IDEAL BODY WEIGHT UNLESS ACTUAL BODY WEIGHT IS LESS

d) SUBSTITION MAY BE PERMITTED BASED ON AVAILABILITY. IF ALTERNATIVE PRODUCT REQUESTED/SUBSTITUTED.

**PREFERRED BRAND NAME:**_____

| SELECT | DOSE | ROUTE | RATE | REPEAT EVERY | DURATION |
|---|---|---|---|---|---|
| | **g / kg** | **IV** | | | |
| | **Flat Dose: g** | **IV** | | | |

**PREMEDS**

| SELECT | MEDICATION | DOSE | ROUTE |
|---|---|---|---|
| | **BENADRYL** | | |
| | **ACETAMINOPHEN** | | |
| | **SOLUMEDROL** | | |
| | **FAMOTIDINE** | | |
| | **Other:** | | |

**LABS**

| SELECT | LAB REQUESTED | WHEN | FREQUENCY |
|---|---|---|---|
| | **BMP** | **( ) PRIOR ( ) POST** | |
| | **CMP** | **( ) PRIOR ( ) POST** | |
| | **BUN/CREATININE** | **( ) PRIOR ( ) POST** | |
| | **Other:** | **( ) PRIOR ( ) POST** | |
| | **Other:** | **( ) PRIOR ( ) POST** | |

**NOTES/SPECIAL INSTRUCTIONS**

_____

_____

_____

_____

_____

**Physician's Signature** _____ **Time**_____ **Date**_____

**Signature Must Be Clear and Legible*

**Cosignature (If Required)**_____ **Time**_____ **Date**_____

**Signature Must Be Clear and Legible*

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☐ **STAT REFERRAL**

## OSTEOPOROSIS ORDER FORM

**PATIENT INFORMATION**

Last Name: _____ First Name: _____ MI_____ DOB:_____

HT: _____ in WT: _____ kg Birth Sex :( ) Male ( ) Female Allergies: ( ) NKDA, (Or):_____

_____

Provider Name_____ Contact Name _____ Contact Phone # _____

NPI #:_____ Tax ID #:_____ Fax #: _____

**STATEMENT OF MEDICAL NECESSITY**

Primary Diagnosis: (ICD-10 CODE + DESCRIPTION)

_____ Date of Diagnosis: _____

**PERTINENT MEDICAL HISTORY**

Does patient have venous access? ☐ **YES** ☐ **NO** **If yes, what type** ☐ **MEDIPORT** ☐ **PIV** ☐ **PICC LINE** ☐ **OTHER:**_____

a) BIOSIMILAR EQUIVALENT SUBSTITUTION MAY APPLY

**PRESCRIPTION ORDERS**

| SELECT | MEDICATION | DOSE | ROUTE | FREQUENCY | DURATION |
|---|---|---|---|---|---|
| | **RECLAST (ZOLEDRONIC ACID)**<br>ADMINISTER OVER NO LESS THAN 15 MINUTES<br>BUN, CREAT, AND CALCIUM LEVEL WITHIN 30 DAYS OF APPOINTMENT<br>HOLD IF CALCIUM LEVELS < 8.5mg/dL or IONIZED CALCIUM LEVEL < 4.5mg/dL or IF CRCL < 35 ML/MIN | **5 mg** | **IV** | **ONCE EVERY 12 MONTHS** | **1 Year** |
| | **PROLIA (DENOSUMAB)**<br>BUN, CREAT, CALCIUM LEVEL WITIN 90 DAYS OF THE APPOINTMENT<br>HOLD IF CALCIUM LEVELS < 8.5mg/dL or IONIZED CALCIUM LEVEL < 4.5mg/dL or IF CRCL < 30 ML/MIN | **60 mg** | **Sub Q** | **ONCE EVERY 6 MONTHS** | **1 Year** |
| | **EVENITY**<br>BUN, CREAT, CALCIUM LEVEL WITIN 90 DAYS OF THE APPOINTMENT<br>HOLD IF CALCIUM LEVELS < 8.5 mg/dL or IONIZED CALCIUM LEVEL < 4.5 mg/dL or IF CRCL < 30 ML/MIN | **210 mg** | **Sub Q** | **ONCE EVERY MONTH x 12** | **1 Year** |

**LAB ORDERS: Calcium, BUN, Serum Creatinine will be drawn prior to administration is previous results not provided within 90 days of appointment.**

**SUPPORTING DOCUMENTATION FOR PATIENTS RECEIVING RECLAST, PROLIA, OR EVENITY:**

1) **OSTEOPOROSIS**
- **CALCIUM, BUN, AND SERUM CREATININE TO BE CHECKED WITHIN 30 DAYS FOR PATIENTS TAKING RECLAST OR 90 DAYS FOR PATIENTS TAKING PROLIA**
- **ORIGINAL BONE DENSITY/DEXA SCAN SUPPORTING THE DIAGNOSIS OF OSTEOPOROSIS**
- **H+P OR OFFICE NOTES LISTING THE DIAGNOSIS OF OSTEOPOROSIS IN THE PATIENT RECORD DATED WITHIN 1 YEAR PRIOR TO APPOINTMENT**
- **PRIOR/CURRENT MEDICATIONS USED TO TREAT THE DIAGNOSIS OF OSTEOPOROSIS 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 FOR NONMETASTATIC PROSTATE CANCER**

3) **TREATMENT TO INCREASE BONE MASS IN WOMEN AT HIGH RISK FOR FRACTURE RECEIVING AROMATASE INHIBITOR THERAPY FOR BREAST CANCER**

***OSTEOPENIA IS NOT AN APPROVED DIAGNOSIS FOR PROLIA (DENOSUMAB). PATIENTS WITH IMPRESSIONS OF OSTEOPENIA MUST HAVE AN ORIGINAL BONE DENISTY RESULT OR DEXA SCAN SUPPORTING THE DIAGNOSIS OF OSTEOPOROSIS OR DOCUMENTATION OF A PREVIOUS FRAGILITY FRACTURE.**

***PLEASE SUBMIT DOCUMENTATION OF ANY TRIED AND FAILED ORAL / INJECTIBLE MEDICATIONS ALONG WITH THE SUPPORTING DOCUMENTATION OF THE PATIENT RESPONSE / FAILURE TO TREATMENT.**

***PROLIA, RECLAST, AND EVENITY ARE CONTRAINDICATED IN PATIENTS WITH HYPOCALCEMIA.**

***EVENITY SHOULD NOT BE ADMINISTERED TO PATIENTS WHO HAVE A HISTORY OF STROKE OR MI (MYOCARDIAL INFARCTION) WITHIN THE LAST 12 MONTHS.**

**Physician's Signature** _____ **Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

**Cosignature (If Required)**_____ **Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

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☐ **STAT REFERRAL**

## BONE MARROW STIMULATING AGENTS ORDER FORM

**PATIENT INFORMATION**

Last Name: _____ First Name: _____ MI_____ DOB:_____

HT: _____ in WT: _____ kg Birth Sex :( ) Male ( ) Female Allergies: ( ) NKDA, (Or):_____

_____

Provider Name_____ Contact Name _____ Contact Phone # _____

NPI #:_____ Tax ID #:_____ Fax #: _____

**STATEMENT OF MEDICAL NECESSITY** Primary Diagnosis: (ICD-10 Code plus Description)

_____

Date of Diagnosis: _____

**PRESCRIPTION ORDERS**

a) BIOSIMILAR EQUIVALENT SUBSTITUTION MAY APPLY

Collect CBC prior to each injection (s) and fax results to:_____

Hold erythropoietin injections if Hemoglobin is ≥ to _12 g/dL__

| 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 Signature** _____**Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

**Cosignature (If Required)**_____ **Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

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☐ **STAT REFERRAL**

## ASTHMA AGENT ORDER FORM

**PATIENT INFORMATION**

Last Name: _____ First Name: _____ MI_____ DOB:_____

HT: _____ in WT: _____ kg Birth Sex :( ) Male ( ) Female Allergies: ( ) NKDA, (Or):_____

_____

Provider Name_____ Contact Name _____ Contact Phone # _____

NPI #:_____ Tax ID #:_____ Fax #: _____

**STATEMENT OF MEDICAL NECESSITY**

Primary Diagnosis: (ICD-10 Code plus Description)

_____

Date of Diagnosis: _____

**PRESCRIPTION ORDERS**

a) WEIGHT BASED DOSING WILL REMAIN FOR DURATION OF ORDER UNLESS WEIGHT CHANGES +/- BY 10 %

b) Pretreatment Serum IgE (Xolair) _____ units / mL

| SELECT | MEDICATION | DOSE | ROUTE | FREQUENCY | DURATION |
|---|---|---|---|---|---|
| | XOLAIR | ____ 150 mg<br>____ 225 mg<br>____ 300 mg<br>____ 375 mg | Sub Q | 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 weeks | |
| | NUCALA | 100 MG | Sub Q | Every 4 weeks | |
| | TEZSPIRE | 210 mg | Sub Q | Every 4 weeks | |

**PREMEDS**

| SELECT BELOW | MEDICATION | DOSE | ROUTE |
|---|---|---|---|
| | NONE | NA | NA |
| | BENADRYL (diphenhydramine) | | |
| | TYLENOL (acetaminophen) | | |
| | OXYGEN | | |
| | Other: | | |
| | Other: | | |
| | Other: | | |

**LABS**

| SELECT BELOW | LAB REQUESTED | WHEN | FREQUENCY |
|---|---|---|---|
| | NONE | NA | NA |
| | BMP | ( ) PRIOR ( ) POST | |
| | CMP | ( ) PRIOR ( ) POST | |
| | BUN/CREATININE | ( ) PRIOR ( ) POST | |
| | CRP: | ( ) PRIOR ( ) POST | |
| | ESR: | ( ) PRIOR ( ) POST | |
| | Other: | ( ) PRIOR ( ) POST | |

**NOTES:**

_____

_____

**Physician's Signature** _____ **Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

**Cosignature (If Required)**_____ **Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

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INFUSION CENTER
Phone: 432-758-4716 Fax: 877-249-1191

☐ **STAT REFERRAL**

# RHEUMATOLOGY ORDER FORM

## PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____ DOB:_____

HT: _____ in WT: _____ kg Birth Sex :( ) Male ( ) Female Allergies: ( ) NKDA, (Or):_____

_____

Provider Name_____ Contact Name _____ Contact Phone # _____

NPI #:_____ Tax ID #:_____ Fax #: _____

## STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD-10 Code plus Description)

_____

## PERTINENT MEDICAL HISTORY

Does patient have venous access? ☐ **YES** ☐ **NO** **If yes, what type** ☐ **MEDIPORT** ☐ **PIV** ☐ **PICC LINE** ☐ **OTHER:**_____

1) TB test performed? ○ Yes ○ No Date:_____ Results,_____

2) Hep-B antigen surface antibody test? ○ Yes ○ No Date: _____

3) Patient previously treated with any of the following: (please select) ○ Remicade ○ Inflectra ○ Simponi Aria ○ Benlysta ○ Rituxan ○ Orencia ○ Actemra ○ Stelara, Date: _____

## PRESCRIPTION ORDERS:

a) ALL MEDIPORTS / IV ACCESSES WILL BE FLUSHED WITH SALINE PER HOSPITAL PROTOCOL PRN UNLESS OTHERWISE NOTED BY PROVIDER

b) ALL PRODUCTS WILL BE PREPARED AND ADMINISTERED PER STANDARD PHARMACY CONCENTRATIONS AND HOSPITAL POLICY

c) DOSES MAY BE ROUNDED TO NEAREST VIAL SIZE WITHIN 10% OF PRESCRIBED DOSE. WEIGHT BASED DOSING TO REMAIN UNLESS WEIGHT CHANGES +/- BY____ %

d) BIOSIMILAR EQUIVALENT SUBSTITUTION MAY APPLY

| Select | MEDICATION | DOSE | ROUTE | FREQUENCY | DURATION |
|---|---|---|---|---|---|
| | **Actemra (Max Dose = 800mg)** | **mg/kg** | **IV** | **Every 4 Weeks** | |
| | **Benlysta Loading Dose(s)** | **10 mg / kg** | **IV** | **0, 2, 4 Weeks, Then Once Every 4 Weeks** | |
| | **Benlysta Maintenance Dose** | **10 mg / kg** | **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 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 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 Weeks** | |
| | **Stelara Loading Dose(s)** ***Sub Q administration is NOT covered Outpatient*** | **mg** | **IV** | **Once** | **1** |

**PREMEDS**

| SELECT | MEDICATION | DOSE | ROUTE |
|---|---|---|---|
| | **NONE** | **NA** | **NA** |
| | **BENADRYL (diphenhydramine)** | | |
| | **TYLENOL (acetaminophen)** | | |
| | **PEPCID (famotidine)** | | |
| | **SOLU-MEDROL (methylprednisolone)** | | |
| | **ZOFRAN (ondansetron)** | | |
| | **Other:** | | |
| | **Other:** | | |
| | **Other:** | | |
| | **OXYGEN:** | | |

**LABS**

| SELECT | LAB REQUESTED | WHEN | FREQUENCY |
|---|---|---|---|
| | **NONE** | **NA** | **NA** |
| | **BMP** | | |
| | **CMP** | | |
| | **BUN/CREATININE** | | |
| | **CRP** | | |
| | **ESR** | | |
| | **ALT** | | |
| | **AST** | | |
| | **LIVER PANEL** | | |
| | **OTHER:** | | |

**Physician's Signature** _____ **Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

**Cosignature (If Required)**_____ **Time**_____ **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.**

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Phone: 432-758-4716 Fax: 877-249-1191

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## IRON PRODUCT ORDER FORM

**PATIENT INFORMATION**

Last Name: _____ First Name: _____ MI_____ DOB:_____

HT: _____ in WT: _____ kg Birth Sex :( ) Male ( ) Female Allergies: ( ) NKDA, (Or):_____

_____

Provider Name_____ Contact Name _____ Contact Phone # _____

NPI #:_____ Tax ID #:_____ Fax #: _____

**STATEMENT OF MEDICAL NECESSITY**

Primary Diagnosis: (ICD-10 Code plus Description)

_____Date of Diagnosis: _____

**PERTINENT MEDICAL HISTORY**

Does patient have venous access? ☐ **YES** ☐ **NO** **If yes, what type** ☐ **MEDIPORT** ☐ **PIV** ☐ **PICC LINE** ☐ **OTHER:**_____

**PRESCRIPTION ORDERS**

a) ALL MEDIPORTS/IV ACCESS WILL BE ACCESSED AND FLUSHED WITH SALINE PER HOSPITAL PROTOCOL PRN UNLESS OTHERWISE NOTED BY PROVIDER
b) ALL PRODUCTS WILL BE PREPARED AND ADMINISTERED PER STANDARD PHARMACY CONCENTRATIONS AND HOSPITAL POLICY
c) SUPPORTING LABWORK AND DOCUMENTATION OF ORAL IRON TREATMENT MAY BE REQUIRED BASED ON INDIVIDUAL PAYOR GUIDELINES
d) PRODUCT SUBSTITUTION MAY APPLY BASED ON AVAILABILITY OR INSURANCE REQUIREMENTS
e) PATIENTS TAKING FERAHEME MUST BE OBSERVED FOR 30 MINUTES POST INFUSION. BP AND PULSE MUST BE COLLECTED

| SELECT | MEDICATION | DOSE | ROUTE | FREQUENCY | DURATION |
|---|---|---|---|---|---|
| | **VENOFER** | **mg** | **IV** | | |
| | **VENOFER** | **200 mg** | **IV** | **ONCE EVERY WEEK** | **5 Doses** |
| | **INJECTAFER** | **750 mg** | **IV** | **ONCE EVERY WEEK** | **2 Doses** |
| | **INJECTAFER (*PATIENT WEIGHT > 50 kg)*** | **15 mg / kg** | **IV** | **ONCE EVERY WEEK** | **2 Doses** |
| | **FERRLECIT** | **125 mg** | **IV** | | |
| | **FERRLECIT** | **250 mg** | **IV** | | |
| | **FERAHEME** | **510 mg** | **IV** | **ONCE, THEN REPEAT 3 – 8 DAYS LATER** | **2 Doses** |
| | **OTHER:** | | | | |

**PREMEDS**

| SELECT BELOW | MEDICATION | DOSE | ROUTE |
|---|---|---|---|
| | **NONE** | **NA** | **NA** |
| | **BENADRYL (diphenhydramine)** | **50 mg** | **IV** |
| | **TYLENOL (acetaminophen)** | | |
| | **EPINEPHRINE** | **0.3mg / 0.3ml** | **IM** |
| | **SOLU-MEDROL (methylprednisolone)** | **125 mg** | **IVP** |
| | **Other:** | | |
| | **OXYGEN:** | | |

**LABS**

| SELECT BELOW | LAB REQUESTED | WHEN | FREQUENCY |
|---|---|---|---|
| | **NONE** | **NA** | **NA** |
| | **BMP** | **( ) PRIOR ( ) POST** | |
| | **CMP** | **( ) PRIOR ( ) POST** | |
| | **BUN/CREATININE** | **( ) PRIOR ( ) POST** | |
| | **H+H:** | **( ) PRIOR ( ) POST** | |
| | **Ferritin:** | **( ) PRIOR ( ) POST** | |
| | **Other:** | **( ) PRIOR ( ) POST** | |

**NOTES:**_____

**Physician's Signature** _____**Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

**Cosignature (If Required)**_____ **Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

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## THERAPEUTIC PHLEBOTOMY ORDER FORM

**PATIENT INFORMATION**

Last Name: _____ First Name: _____ MI_____ DOB:_____

HT: _____ in WT: _____ kg Birth Sex :( ) Male ( ) Female Allergies: ( ) NKDA, (Or):_____

_____

Provider Name_____ Contact Name _____ Contact Phone # _____

NPI #:_____ Tax ID #:_____ Fax #: _____

**STATEMENT OF MEDICAL NECESSITY**

Primary Diagnosis: (ICD 10 CODE + DESCRIPTION) Secondary Diagnosis: (ICD 10 CODE + DESCRIPTION)

_____ _____

**PRESCRIPTION ORDERS**

a) ALL MEDIPORTS / IV ACCESSES WILL BE FLUSHED WITH SALINE PER HOSPITAL PROTOCOL PRN UNLESS OTHERWISE NOTED BY PROVIDER
b) 10ml NS Flush Syringe PRN
c) ORDERS WITH INCOMPLETE PARAMETERS WILL NOT BE SERVICED

| | ML TO REMOVE (+/- 50ML) | PARAMATERS | FREQUENCY | DURATION |
|---|---|---|---|---|
| **Therapeutic Phlebotomy** | | **HOLD if ≤** | ☐ **1 x only**<br>☐ **Weekly**<br>☐ **Monthly**<br>☐ **Other:** | |

**LABS**

| SELECT BELOW | LAB REQUESTED | FREQUENCY |
|---|---|---|
| | **NONE** | **NA** |
| | **CBC w/ Diff** | **PRIOR TO EACH PHLEBOTOMY** |
| | **Hgb** | **PRIOR TO EACH PHLEBOTOMY** |
| | **Hct** | **PRIOR TO EACH PHLEBOTOMY** |
| | **BMP** | |
| | **CMP** | |
| | **BUN/CREATININE** | |
| | **ESR** | |
| | **CRP** | |
| | **CPK** | |
| | **Ferritin** | |
| | **Other:** | |
| | **Other:** | |

**NOTES/INSTRUCTIONS/OTHER**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

**Physician's Signature** _____ **Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

**Cosignature (If Required)**_____ **Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

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## HEADACHE ORDER FORM

**PATIENT INFORMATION**

Last Name: _____ First Name: _____ MI_____ DOB:_____

HT: _____ in WT: _____ kg Birth Sex :( ) Male ( ) Female Allergies: ( ) NKDA, (Or):_____

_____

Provider Name_____ Contact Name _____ Contact Phone # _____

NPI #:_____ Tax ID #:_____ Fax #: _____

**STATEMENT OF MEDICAL NECESSITY**

Primary Diagnosis: (ICD-10 Code plus Description)

_____ Date of Diagnosis: _____

**PERTINENT MEDICAL HISTORY**

Does patient have venous access? ☐ **YES** ☐ **NO** **If yes, what type** ☐ **MEDIPORT** ☐ **PIV** ☐ **PICC LINE** ☐ **OTHER:**_____

**PRESCRIPTION ORDERS**

| SELECT | MEDICATION | DOSE | ROUTE | FREQUENCY | DURATION |
|---|---|---|---|---|---|
| | **BENADRYL (diphenhydramine)** | | | | |
| | **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** | **Once Every 3 Months** | |
| | **0.9% SODIUM CHLORIDE** | | | | |

**PREMEDS**

| SELECT BELOW | MEDICATION | DOSE | ROUTE |
|---|---|---|---|
| | **NONE** | **NA** | **NA** |
| | **BENADRYL (diphenhydramine)** | | |
| | **TYLENOL (acetaminophen)** | | |
| | **ZOFRAN (ondansetron)** | | |
| | **Other:** | | |
| | **Other:** | | |
| | **OXYGEN** | | |

**LABS**

| SELECT BELOW | LAB REQUESTED | WHEN | FREQUENCY |
|---|---|---|---|
| | **NONE** | **NA** | **NA** |
| | **BMP** | **( ) PRIOR ( ) POST** | |
| | **CMP** | **( ) PRIOR ( ) POST** | |
| | **BUN/CREATININE** | **( ) PRIOR ( ) POST** | |
| | **CRP:** | **( ) PRIOR ( ) POST** | |
| | **ESR:** | **( ) PRIOR ( ) POST** | |
| | **Other:** | **( ) PRIOR ( ) POST** | |

**Physician's Signature** _____ **Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

**Cosignature (If Required)**_____ **Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

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## ANTIBIOTICS ORDER FORM

**PATIENT INFORMATION**

Last Name: _____ First Name: _____ MI_____ DOB:_____

HT: _____ in WT: _____ kg Birth Sex :( ) Male ( ) Female Allergies: ( ) NKDA, (Or):_____

_____

Provider Name_____ Contact Name _____ Contact Phone # _____

NPI #:_____ Tax ID #:_____ Fax #: _____

**PRIMARY DIAGNOSIS**:_____ **SECONDARY DIAGNOSIS**:_____

Does patient have venous access? ☐ YES ☐ NO If "YES", what type? ☐ MEDIPORT ☐ PIV ☐ PICC LINE ☐ MID LINE ☐ OTHER:_____

**PICC LINE INSTRUCTIONS MUST BE SELECTED (Check the option)**: ☐ DISCHARGE PICC AFTER LAST DOSE ☐ LINE CARE PER HOSPITAL PROTOCOL UNTIL LINE IS REMOVED

a) ALL MEDIPORTS/IV ACCESSES MAY BE FLUSHED WITH SALINE PER HOSPITAL PROTOCOL PRN UNLESS OTHERWISE NOTED BY PROVIDER

b) HOSPITAL PHARMACY WILL FOLLOW AND ADJUST DOSING FOR VANCOMYCIN, GENTAMICIN, AND MAY INTERVENE PER HOSPITAL PROTOCOL FOR PATIENT SAFETY

| SELECT | DRUG | DOSE | ROUTE | REPEAT EVERY | DURATION |
|---|---|---|---|---|---|
| | Vancomycin | 500 mg | IV | | |
| | Vancomycin | 750 mg | IV | | |
| | Vancomycin | 1000 mg | IV | | |
| | Vancomycin | 1500 mg | IV | | |
| | Vancomycin | 1750 mg | IV | | |
| | Vancomycin | 2000 mg | IV | | |
| | Rocephin (Ceftriaxone) | 250 mg | ( ) IV ( ) IM | | |
| | Rocephin (Ceftriaxone) | 500 mg | ( ) IV ( ) IM | | |
| | Rocephin (Ceftriaxone) | 750 mg | ( ) IV ( ) IM | | |
| | Rocephin (Ceftriaxone) | 1000 mg | ( ) IV ( ) IM | | |
| | Rocephin (Ceftriaxone) | 2000 mg | ( ) IV ( ) IM | | |
| | Invanz (Ertapenem) | 500 mg | ( ) IV ( ) IM | | |

| SELECT | DRUG | DOSE | ROUTE | REPEAT EVERY | DURATION |
|---|---|---|---|---|---|
| | Invanz (Ertapenem) | 1000 mg | ( ) IV ( ) IM | | |
| | Merrem (Meropenem) | 500 mg | ( ) IV | | |
| | Merrem (Meropenem) | 1000 mg | ( ) IV | | |
| | Gentamicin (Garamycin) | | ( ) IV | | |
| | Gentamicin (Garamycin) | 7mg/kg | ( ) IV | | |
| | Levaquin (Levofloxacin) | 250 mg | IV | | |
| | Levaquin (Levofloxacin) | 500 mg | IV | | |
| | Levaquin (Levofloxacin) | 750 mg | IV | | |
| | Dalvance (Dalbavancin) | 1500 mg | IV | NA | X 1 Dose |
| | Dalvance (Dalbavancin) | 1000 mg Day 1, 500mg Day 8 | IV | | |
| | Orbactiv (Oritavancin) | 1200 mg | IV | | |
| | Other: | | | | |

**Other (not listed):**

| SELECT | LAB REQUESTED | WHEN | FREQUENCY |
|---|---|---|---|
| | **NONE** | NA | NA |
| | **BMP** | PRIOR ( ) POST ( ) | |
| | **CMP** | PRIOR ( ) POST ( ) | |
| | **BUN/CREATININE** | PRIOR ( ) POST ( ) | |
| | **CRP** | PRIOR ( ) POST ( ) | |
| | **ESR** | PRIOR ( ) POST ( ) | |
| | **ALT** | PRIOR ( ) | |
| | **VANCO TROUGH** | | |
| | **GENT TROUGH** | | |

| SELECT | LAB REQUESTED | WHEN | FREQUENCY |
|---|---|---|---|
| | **CK** | PRIOR ( ) POST ( ) | |
| | **UA** | PRIOR ( ) POST ( ) | |
| | **Other:** | PRIOR ( ) POST ( ) | |
| | **Other:** | PRIOR ( ) POST ( ) | |
| | **Other:** | PRIOR ( ) POST ( ) | |
| | **Other:** | PRIOR ( ) POST ( ) | |
| | **Other:** | | |
| | **Other**: | | |
| | **Other:** | | |

**NOTES:**_____

_____

**Physician's Signature** _____ **Time**_____ **Date**_____

**Signature must be clear and legible*

**Co-Signature (If Required)** _____ **Time**_____ **Date**_____

**Signature must be clear and legible*

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# LEQEMBI ORDER FORM

**PATIENT INFORMATION**

Last Name: _____ First Name: _____ MI_____ DOB:_____

HT: _____ in WT: _____ kg Birth Sex :( ) Male ( ) Female Allergies: ( ) NKDA, (Or):_____

_____

Provider Name_____ Contact Name _____ Contact Phone # _____

NPI #:_____ Tax ID #:_____ Fax #: _____

Does patient have venous access? ☐ **YES** ☐ **NO** **If yes, what type** ☐ **MEDIPORT** ☐ **PIV** ☐ **PICC LINE** ☐ **OTHER:**_____

a) ALL MEDIPORTS / IV ACCESSES WILL BE FLUSHED WITH SALINE PER HOSPITAL PROTOCOL PRN UNLESS OTHERWISE NOTED BY PROVIDER

***PLEASE SELECT FROM BELOW:***

_____ Perform port flush every _____ weeks per hospital protocol.
_____ Perform IV site care per hospital protocol.
_____ Activase 2mg IVP per hospital protocol.

**DUAL DIAGNOSIS IS REQUIRED – SELECT ONE OPTION OF BOTH CONDITIONS THAT APPLY FROM BELOW:**

□ G30.0 Alzheimer's Disease, Early Onset
□ G30.1 Alzheimer's Disease, Late Onset
□ G30.8 Other Alzheimer's disease
□ G30.9 Alzheimer's disease, unspecified
□ G31.84 Mild Cognitive Impairment, So Stated
← G30.X codes require secondary F02.8X code →
□ F02.80 Dementia without behavioral disturbance
□ F02.81 Dementia with behavioral disturbance
□ Other:_____ (ICD 10 + Description)

**Prescriber must indicate the following requirements have been met (please provide documentation):**

□ Beta Amyloid Pathology Confirmed Via

□ Amyloid PET Scan Date:_____ **OR** □ CSF Analysis Date:_____ Result:_____

□ Cognitive Assessment Used:_____ Date:_____ Result:_____

□ ApoE ε4 Genetic Test Date:_____ Result: ☐ Homozygote ☐ Heterozygote ☐ Noncarrier

**PRESCRIPTION ORDERS**

| 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 baseline MRI results prior to initiation of treatment.
☑ Confirm MRI completed and reviewed by prescriber prior to the 5th, 7th, and 14th treatment.
☑ Measure and record weight prior to each treatment to determine dose.
☑ **Hold infusion and notify provider if patient reports:**

- Headache.
- Dizziness.
- Nausea.
- Vision changes.
- New or worsening confusion.

**Post-Infusion:**

☑ Educate patient/caregiver to report headache, dizziness, nausea, vision changes, or new/worsening confusion.

**Physician's Signature** _____ **Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

**Cosignature (If Required)**_____ **Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

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☐ **STAT REFERRAL**

# ACTH STIMULATION TEST ORDER FORM

## PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____ DOB:_____

HT: _____ in WT: _____ kg Birth Sex :( ) Male ( ) Female Allergies: ( ) NKDA, (Or):_____

_____

Provider Name_____ Contact Name _____ Contact Phone # _____

NPI #:_____ Tax ID #:_____ Fax #: _____

## STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD 10 CODE + DESCRIPTION)

_____

Secondary Diagnosis: (ICD 10 CODE + DESCRIPTION)

_____

Does patient have venous access? ☐ **YES** ☐ **NO** **If yes, what type** ☐ **MEDIPORT** ☐ **PIV** ☐ **PICC LINE** ☐ **OTHER:**_____

## PRESCRIPTION ORDERS

a) ALL MEDIPORTS / IV ACCESSES WILL BE FLUSHED WITH SALINE PER HOSPITAL PROTOCOL PRN UNLESS OTHERWISE NOTED BY PROVIDER

| SELECT | MEDICATION | DOSE | ROUTE | FREQUENCY | DURATION |
|---|---|---|---|---|---|
| | **COSYNTROPIN 250 MCG/2ML (NS)** | **2 ML** | **IV Push over 2 minutes** | **ONCE** | **1** |

**LABS**

| SELECT BELOW | LAB REQUESTED | FREQUENCY |
|---|---|---|
| X | **ACTH LEVEL** | **PRIOR** |
| X | **CORTISOL LEVEL** | **PRIOR AND REPEAT 30 + 60 MINUTES POST INFUSION** |
| | **Other:** | |
| | **Other:** | |
| | **Other:** | |
| | **Other:** | |

**NOTES/INSTRUCTIONS/OTHER**

_____
_____
_____
_____
_____
_____

1) **Vital signs will be measured prior to beginning test AND at completion of test, and with any clinical changes that occur during the test. Notify physician if SBP > 180, DBP > 110, or pulse > 120**

2) **Flush line with 10mL 0.9% NS then DC IV access.**

**Physician's Signature** _____**Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

**Cosignature (If Required)**_____ **Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

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## LEQVIO ORDER FORM

**PATIENT INFORMATION**

Last Name: _____ First Name: _____ MI_____ DOB:_____

HT: _____ in WT: _____ kg Birth Sex :( ) Male ( ) Female Allergies: ( ) NKDA, (Or):_____

_____

Provider Name_____ Contact Name _____ Contact Phone # _____

NPI #:_____ Tax ID #:_____ Fax #: _____

**STATEMENT OF MEDICAL NECESSITY**

Primary Diagnosis: (ICD 10 CODE + DESCRIPTION) Secondary Diagnosis: (ICD 10 CODE + DESCRIPTION)

_____ _____

Does patient have venous access? ☐ **YES** ☐ **NO** **If yes, what type** ☐ **MEDIPORT** ☐ **PIV** ☐ **PICC LINE** ☐ **OTHER:**_____

**PRESCRIPTION ORDERS**

a) ALL MEDIPORTS / IV ACCESSES WILL BE FLUSHED WITH SALINE PER HOSPITAL PROTOCOL PRN UNLESS OTHERWISE NOTED BY PROVIDER
b) ALL PRODUCTS WILL BE PREPARED AND ADMINISTERED PER STANDARD PHARMACY CONCENTRATIONS AND HOSPITAL POLICY

| SELECT | MEDICATION | DOSE | ROUTE | FREQUENCY | DURATION |
|---|---|---|---|---|---|
| | **LEQVIO (LOADING DOSES)** | **284 mg** | **SQ** | **Month 0 and 3, then every 6 months** | |
| | **LEQVIO (MAINTANENCE DOSES)** | **284 mg** | **SQ** | **Every 6 months** | |

**LABS**

| SELECT BELOW | LAB REQUESTED | FREQUENCY |
|---|---|---|
| | | |
| | | |

**SUPPORTING DOCUMENTATION FOR PATIENTS RECEIVING LEQVIO**

1) **SUPPORTING CLINICAL NOTES TO INCLUDE ANY PAST TRIED AND/OR FAILED THERAPIES, INTOLERANCE, BENEFITS, OR CONTRAINDICATIONS TO CONVENTIONAL THERAPY**

2) **HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HEFH) - DOES THE PATIENT HAVE A UNTREATED LDL ≥ 190MG/DL (≥ 155MG/DL IF <16 YEARS OF AGE)? ☐ YES ☐ NO**

3) **PLEASE MARK ANY OF THE FOLLOWING CRITERIA THE HEFH PATIENT MEETS:**
   - ☐ **PRESENCE OF TENDON XANTHOMA(S) IN THE PATIENT OR 1ST/2ND DEGREE RELATIVE**
   - ☐ **FAMILY HISTORY OF MI AT <60 YEARS OLD IN 1ST DEGREE RELATIVE OR <50 YEARS OLD IN 2ND DEGREE RELATIVE**
   - ☐ **FAMILY HISTORY OF TOTAL CHOLESTEROL > THAN 290MG/DL IN A 1ST/2ND DEGREE RELATIVE**
   - ☐ **ARCUS CORNEALIS BEFORE AGE 45**

4) **ASCVD - DOES THE PATIENT'S LDL REMAIN ≥ 100MG/DL DESPITE TREATMENT WITH A HIGH-INTENSITY STATIN? ☐ YES ☐ NO**

5) **HAS THE PATIENT TRIED AND FAILED PCSK9 INHIBITOR AFTER 12 WEEKS OF USE? ☐ YES ☐ NO**

6) **HAS THE PATIENT TRIED AND FAILED A HIGH INTENSITY STATIN FOR ≥ 8 CONTINUOUS WEEKS? ☐ YES ☐ NO**

7) **INDICATE ANY CONDITIONS THE PATIENT HAS:**
   - ☐ **ACUTE CORONARY SYNDROME**
   - ☐ **CORONARY OR OTHER ARTERIAL REVASCULARIZATION**
   - ☐ **PERIPHERAL ARTERIAL DISEASE PRESUMED TO BE OF ATHEROSCLEROTIC ORIGIN**
   - ☐ **HISTORY OF MYOCARDIAL INFARCTION**
   - ☐ **TRANSIENT ISCHEMIC ATTACK**
   - ☐ **STROKE**

8) **INCLUDE LABS AND/OR TEST RESULTS TO SUPPORT DIAGNOSIS**
   - ☐ **LDL-C (Required)**
   - ☐ **MUTATION IN LDL, APOB, OR PCSK9 GENE (If Applicable)**

9) **OTHER MEDICAL NECESSITY:** _____

**Physician's Signature** _____ **Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

**Cosignature (If Required)**_____ **Time**_____ **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.**