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

☐ **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*

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