



**BHI Infusion Clinic**  
 Phone: 270-580-2228  
 Fax: 877-249-1191

**STAT REFERRAL**

**BLOOD PRODUCT TRANSFUSION ORDER FORM**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_ DOB: \_\_\_\_\_

HT: \_\_\_\_\_ in WT: \_\_\_\_\_  lbs  kg Sex:  Male  Female Allergies:  NKDA, \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Ordering Physician: \_\_\_\_\_ 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) Has the patient taken Darzalex (daratumumab) within the last 6 months?  Yes  No

2) Has type and cross been drawn?  Yes  No If yes, date and time \_\_\_\_\_. If no, patient instructed to go to BHI lab on \_\_\_\_\_ date/time OR \_\_\_\_\_ to be drawn at Infusion Center on arrival.

3) Has the patient received previous blood transfusions?  Yes  No If yes, what facility completed the transfusion \_\_\_\_\_ provider who ordered it \_\_\_\_\_.

4) If yes to question 3, has the patient ever had a reaction to a transfusion or been informed they have a positive antibody screen and/or require additional tests before transfusions?  
 Yes  No

NOTES: \_\_\_\_\_

**PRESCRIPTION ORDERS:**

a) ALL MEDIPORTS / IV ACCESS WILL BE ACCESSED AND FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL POLICY PRN

**TYPE, SCREEN, CROSSMATCH**  **TRANSFUSE ON DATE:**

| SELECT                   | # of UNITS | PRODUCT  |
|--------------------------|------------|--|
| <input type="checkbox"/> |            | FRESH FROZEN PLASMA  |
| <input type="checkbox"/> |            | LEUKO REDUCED PRBCs  |
| <input type="checkbox"/> |            | LEUKO REDUCED IRRADIATED PRBCs   |
| <input type="checkbox"/> |            | LEUKO REDUCED PLATELETS  |
| <input type="checkbox"/> |            | LEUKO REDUCED IRRADIATED PLATELETS   |
| <input type="checkbox"/> |            | PLATELETS TYPE SPECIFIC? <input type="radio"/> Yes OR <input type="radio"/> No |
| <input type="checkbox"/> |            | Other: _____   |

**LABS**

| SELECT                   | LAB REQUESTED | WHEN   |
|--------------------------|---------------|--|
| <input type="checkbox"/> | NONE          | NA   |
| <input type="checkbox"/> | BMP           | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |
| <input type="checkbox"/> | CMP           | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |
| <input type="checkbox"/> | CBC w/ DIFF   | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |
| <input type="checkbox"/> | H+H:          | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |
| <input type="checkbox"/> | T+C:          | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |
| <input type="checkbox"/> | Other:        | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |

**PREMEDS**

| SELECT                   | MEDICATION    | DOSE | ROUTE | FREQUENCY |
|--------------------------|---------------|------|-------|-----------|
| <input type="checkbox"/> | NONE          | NA   | NA    | NA        |
| <input type="checkbox"/> | BENADRYL      |      |       |           |
| <input type="checkbox"/> | ACETAMINOPHEN |      |       |           |
| <input type="checkbox"/> | OXYGEN        |      |       |           |
| <input type="checkbox"/> | LASIX         |      |       |           |
| <input type="checkbox"/> | Other:        |      |       |           |

**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.**



**BH Infusion Clinic**  
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**STAT REFERRAL**

**GASTROENTEROLOGY ORDER FORM**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_ DOB: \_\_\_\_\_

HT: \_\_\_\_\_ in WT: \_\_\_\_\_  lbs  kg Sex:  Male  Female Allergies:  NKDA, \_\_\_\_\_

Physician 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  MEDIPOINT  PIV  PICC LINE  OTHER: \_\_\_\_\_

1) TB test performed?  Yes  No Date: \_\_\_\_\_ Results: \_\_\_\_\_

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

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

5) Hep-B antigen surface antibody test?  Yes  No Date: \_\_\_\_\_

**PRESCRIPTION ORDERS:**

a) ALL MEDIPOINTS / IV ACCESSES WILL BE FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL PROTOCOL

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 WILL REMAIN FOR DURATION OF ORDER UNLESS WEIGHT CHANGES +/- BY \_\_\_\_\_ %

| SELECT                   | DOSING OPTIONS   | DOSE                    | ROUTE | FREQUENCY (POPULATE BELOW)  | DURATION |
|--------------------------|--|-------------------------|-------|---|----------|
| <input type="checkbox"/> | ENTYVIO LOADING DOSES  | 300 mg                  | IV    | 0, 2, 6 WEEKS, THEN ONCE EVERY 8 WEEKS  |          |
| <input type="checkbox"/> | ENTYVIO MAINTENANCE DOSE   | 300 mg                  | IV    | ONCE EVERY 8 WEEKS  |          |
| <input type="checkbox"/> | (Select) <input type="checkbox"/> REMICADE / <input type="checkbox"/> INFLECTRA<br>LOADING DOSES     | ___ mg / ___ kg= ___ mg | IV    | 0, 2, 6 WEEKS, THEN ONCE EVERY ___ WEEKS<br>RATE: <input type="checkbox"/> RAPID or <input type="checkbox"/> STANDARD |          |
| <input type="checkbox"/> | (Select) <input type="checkbox"/> REMICADE / <input type="checkbox"/> INFLECTRA<br>MAINTENANCE DOSES | ___ mg / ___ kg= ___ mg | IV    | ONCE EVERY ___ WEEKS<br>RATE: <input type="checkbox"/> RAPID or <input type="checkbox"/> STANDARD                     |          |
| <input type="checkbox"/> | (Select) <input type="checkbox"/> REMICADE / <input type="checkbox"/> INFLECTRA<br>FLAT DOSE         | _____ mg                | IV    | ONCE EVERY ___ WEEKS<br>RATE: <input type="checkbox"/> RAPID or <input type="checkbox"/> STANDARD                     |          |

**PREMEDS**

| SELECT                   | MEDICATION    | DOSE | ROUTE |
|--------------------------|---------------|------|-------|
| <input type="checkbox"/> | NONE          | NA   | NA    |
| <input type="checkbox"/> | BENADRYL      |      |       |
| <input type="checkbox"/> | ACETAMINOPHEN |      |       |
| <input type="checkbox"/> | OXYGEN        |      |       |
| <input type="checkbox"/> | SOLU-MEDROL   |      |       |
| <input type="checkbox"/> | Other:        |      |       |
| <input type="checkbox"/> | Other:        |      |       |
| <input type="checkbox"/> | Other:        |      |       |
| <input type="checkbox"/> | Other:        |      |       |
| <input type="checkbox"/> | Other:        |      |       |
| <input type="checkbox"/> | Other:        |      |       |

**LABS**

| SELECT                   | LAB REQUESTED  | WHEN   | FREQUENCY |
|--------------------------|----------------|--|-----------|
| <input type="checkbox"/> | NONE           | NA   | NA        |
| <input type="checkbox"/> | BMP            | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |           |
| <input type="checkbox"/> | CMP            | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |           |
| <input type="checkbox"/> | BUN/CREATININE | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |           |
| <input type="checkbox"/> | CRP            | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |           |
| <input type="checkbox"/> | ESR            | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |           |
| <input type="checkbox"/> | ALT            | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |           |
| <input type="checkbox"/> | AST            | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |           |
| <input type="checkbox"/> | LIVER PANEL    | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |           |
| <input type="checkbox"/> | VECTRA         | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |           |
| <input type="checkbox"/> | OTHER:         | <input type="checkbox"/> PRIOR <input type="checkbox"/> 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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**STAT REFERRAL**

**GENERAL IV ORDER FORM**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_ DOB: \_\_\_\_\_

HT: \_\_\_\_\_ in WT: \_\_\_\_\_  lbs  kg Sex:  Male  Female Allergies:  NKDA, \_\_\_\_\_

Physician 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 HEPARIN OR SALINE PER HOSPITAL POLICY PRN

**PLEASE SELECT FROM BELOW:**

\_\_\_\_\_ Perform port flush every \_\_\_\_\_ weeks per hospital policy.

\_\_\_\_\_ Perform IV site care per hospital policy.

NOTE: For patients with central venous access, please select:  D/C 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                     |                |           | NOTES/INSTRUCTIONS/OTHER |
|--------------------------|----------------|-----------|--------------------------|
| SELECT                   | LAB REQUESTED  | FREQUENCY |                          |
| <input type="checkbox"/> | NONE           | NA        |                          |
| <input type="checkbox"/> | CBC w/ Diff    |           |                          |
| <input type="checkbox"/> | BMP            |           |                          |
| <input type="checkbox"/> | CMP            |           |                          |
| <input type="checkbox"/> | BUN/CREATININE |           |                          |
| <input type="checkbox"/> | ESR            |           |                          |
| <input type="checkbox"/> | CRP            |           |                          |
| <input type="checkbox"/> | CPK            |           |                          |
| <input type="checkbox"/> | Other:         |           |                          |
| <input type="checkbox"/> | Other:         |           |                          |

Physician's Signature \_\_\_\_\_ Time \_\_\_\_\_ Date \_\_\_\_\_

\*Signature Must Be Clear and Legible

Cosignature (If Required) \_\_\_\_\_ Time \_\_\_\_\_ Date \_\_\_\_\_

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**STAT REFERRAL**

HYDRATION ORDER FORM

PATIENT INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI \_\_\_\_\_ DOB: \_\_\_\_\_

HT: \_\_\_\_\_ in WT: \_\_\_\_\_  lbs  kg Sex:  Male  Female Allergies:  NKDA, \_\_\_\_\_

Physician 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 OR HEPARIN PER HOSPITAL POLICY

PRESCRIPTION ORDERS FOR HYDRATION

Select the fluid requested AND the corresponding rate below

1.)  NORMAL SALINE

2.)  LACTATED RINGERS

|   |   |
|---|---|
| <input type="checkbox"/> 500 mL, IV x _____             | <input type="checkbox"/> 500 mL, IV x _____             |
| <input type="checkbox"/> 1000 mL (1 Liter), IV x _____  | <input type="checkbox"/> 1000 mL (1 Liter), IV x _____  |
| <input type="checkbox"/> 2000 mL (2 Liters), IV x _____ | <input type="checkbox"/> 2000 mL (2 Liters), IV x _____ |

RATE

RATE

|   |   |
|---|---|
| <input type="checkbox"/> BOLUS - GIVEN OVER 1 HOUR  | <input type="checkbox"/> BOLUS - GIVEN OVER 1 HOUR    |
| <input type="checkbox"/> Over 2 hours @ _____ mL/hour   | <input type="checkbox"/> Over 2 hours @ _____ mL/hour |
| <input type="checkbox"/> Over 4 hours @ _____ mL/hour   | <input type="checkbox"/> Over 4 hours @ _____ mL/hour |
| <input type="checkbox"/> Other: _____ mL/hour   | <input type="checkbox"/> Other: _____ mL/hour         |
| <input type="radio"/> _____ MEQ K+ <input type="radio"/> _____ MG MAG <input type="radio"/> _____ Lidocaine 1% 2 mL <input type="radio"/> OTHER: _____ RATE MAY BE ADJUSTED PER HOSPITAL POLICY<br>(K+ max rate of 10mEq/hr)<br>OTHER (PLEASE SPECIFY DRUG, RATE, FREQUENCY, AND DURATION BELOW): |   |

LABS:

NOTES/INSTRUCTIONS/COMMENTS

| SELECT                   | LAB REQUESTED  | FREQUENCY  |  |
|--------------------------|----------------|--|--|
| <input type="checkbox"/> | NONE           | NONE   |  |
| <input type="checkbox"/> | CBC w/ Diff    | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |  |
| <input type="checkbox"/> | BMP            | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |  |
| <input type="checkbox"/> | CMP            | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |  |
| <input type="checkbox"/> | BUN/CREATININE | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |  |
| <input type="checkbox"/> | Other:         | <input type="checkbox"/> PRIOR <input type="checkbox"/> 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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**NEUROLOGY ORDER FORM**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI \_\_\_\_\_ DOB: \_\_\_\_\_

HT: \_\_\_\_\_ in WT: \_\_\_\_\_  lbs  kg Sex:  Male  Female Allergies:  NKDA, \_\_\_\_\_

Physician 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 MEDIPOINTS / IV ACCESSES WILL BE FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL POLICY
- b) ALL PRODUCTS WILL BE PREPARED AND ADMINISTERED FOLLOWING HOSPITAL POLICY

| SELECT                   | MEDICATION / DOSE   | ROUTE | FREQUENCY  | DURATION  |
|--------------------------|---|-------|--|-----------|
| <input type="checkbox"/> | TYSABRI 300 mg<br><i>*PATIENT WILL BE OBSERVED FOR 1 HOUR POST INFUSION</i> | IV    |  | 12 MONTHS |
| <input type="checkbox"/> | OCREVUS LOADING DOSES   | IV    | 300 mg at 0, 2 weeks, then 600mg once every 6 months |           |
| <input type="checkbox"/> | OCREVUS 600 mg MAINTENANCE DOSES  | IV    | Once every 6 months                                  |           |
| <input type="checkbox"/> | SOLU-MEDROL _____mg   | IV    |  |           |

**PREMEDS**

| SELECT                   | MEDICATION    | DOSE | ROUTE |
|--------------------------|---------------|------|-------|
| <input type="checkbox"/> | BENADRYL      |      |       |
| <input type="checkbox"/> | ACETAMINOPHEN |      |       |
| <input type="checkbox"/> | SOLUMEDROL    |      |       |
| <input type="checkbox"/> | OXYGEN        |      |       |
| <input type="checkbox"/> | FAMOTIDINE    |      |       |
| <input type="checkbox"/> | Other:        |      |       |
| <input type="checkbox"/> | Other:        |      |       |

**LABS**

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

**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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**STAT REFERRAL**

**INTRAVENOUS IMMUNO GLOBULIN ORDER FORM**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI \_\_\_\_\_ DOB: \_\_\_\_\_

HT: \_\_\_\_\_ in WT: \_\_\_\_\_  lbs  kg Sex :  Male  Female Allergies:  NKDA, \_\_\_\_\_

Physician 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  MEDIPOINT  PIV  PICC LINE  OTHER: \_\_\_\_\_

**PRESCRIPTION ORDERS:**

- a) ALL MEDIPOINTS / IV ACCESSES WILL BE FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL PROTOCOL
- 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 WILL REMAIN FOR DURATION OF ORDER UNLESS WEIGHT CHANGES +/- BY \_\_\_\_\_%

| SELECT                   | DOSE                           | ROUTE | RATE               | REPEAT EVERY | DURATION |
|--------------------------|--------------------------------|-------|--------------------|--------------|----------|
| <input type="checkbox"/> | _____ mg X _____ kg = _____ mg | IV    | TITRATE PER POLICY |              |          |
| <input type="checkbox"/> | Flat Dose: _____ gm            | IV    | TITRATE PER POLICY |              |          |

**PREMEDS**

| SELECT                   | MEDICATION    | DOSE | ROUTE |
|--------------------------|---------------|------|-------|
| <input type="checkbox"/> | BENADRYL      |      |       |
| <input type="checkbox"/> | ACETAMINOPHEN |      |       |
| <input type="checkbox"/> | SOLUMEDROL    |      |       |
| <input type="checkbox"/> | FAMOTIDINE    |      |       |
| <input type="checkbox"/> | Other:        |      |       |

**LABS**

| SELECT                   | LAB REQUESTED  | WHEN   | FREQUENCY |
|--------------------------|----------------|--|-----------|
| <input type="checkbox"/> | BMP            | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |           |
| <input type="checkbox"/> | CMP            | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |           |
| <input type="checkbox"/> | BUN/CREATININE | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |           |
| <input type="checkbox"/> | Other:         | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |           |
| <input type="checkbox"/> | Other:         | <input type="checkbox"/> PRIOR <input type="checkbox"/> 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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**OSTEOPOROSIS / OSTEOPENIA ORDER FORM**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_ DOB: \_\_\_\_\_

HT: \_\_\_\_\_ in WT: \_\_\_\_\_  lbs  kg Sex :  Male  Female Allergies:  NKDA, \_\_\_\_\_

Physician 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) ALL MEDIPORTS/IV ACCESS WILL BE ACCESSED AND FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL POLICY

**PRESCRIPTION ORDERS**

| SELECT                   | MEDICATION   | DOSE   | ROUTE                                   | FREQUENCY             | DURATION |
|--------------------------|--|--------|---|-----------------------|----------|
| <input type="checkbox"/> | <b>RECLAST (ZOLEDRONIC ACID)</b><br>ADMINISTER OVER NO LESS THAN 15 MINUTES<br>BUN, CREAT, AND CALCIUM LEVEL WITHIN 15 DAYS OF APPOINTMENT. ADD A MAG, PHOS, AND 25 (OH) D (if doing other labs). HOLD IF CALCIUM LEVELS < 8.4 MG/ML or IONIZED CALCIUM LEVEL <or IF CRCL < 35 ML/MIN. (Reclast contraindicated if Creatinine Clearance <35 ml/min or hypocalcemia-corrected calcium <8.4 mg/dl, calculated by Pharmacist). PREHYDRATION WITH SODIUM CHLORIDE 0.9%, FLUSH IV LINE WITH SODIUM CHLORIDE 0.9%, TYLENOL 325 MG TABLET. IF MAGNESIUM <1.7 MG/DL OR PHOSPHORUS <2.5 MG/DL—PATIENT FOLLOW UP WITH PROVIDER | 5 mg   | IV (use vented IV set)                  | ONCE EVERY 12 MONTHS  | 1 Year   |
| <input type="checkbox"/> | <b>PROLIA (DENOSUMAB)</b><br>CALCIUM MUST BE CHECKED WITHIN 30 DAYS OF THE APPOINTMENT. HOLD IF CALCIUM LEVELS < 8.4 MG/ML or IONIZED CALCIUM LEVEL < ADD A PHOSPHORUS, AND 25 (OH) D (if doing a Calcium). (Prolia contraindicated if hypocalcemia—corrected Calcium <8.4 mg/dl, calculated by Pharmacist). IF PHOSPHORUS <2.5 MG/DL—PATIENT FOLLOW UP WITH PROVIDER  | 60 mg  | SC (upper arm, upper thigh, or abdomen) | ONCE EVERY 6 MONTHS   | 1 Year   |
| <input type="checkbox"/> | <b>EVENITY</b><br>CALCIUM LEVEL BEFORE INITIAL DOSE (if not done within previous 30 days) AND THEN EVERY 3 MONTHS (if not done within previous 30 days) (Evenity contraindicated if hypocalcemia—corrected calcium <8.4 mg/dl, calculated by Pharmacist). GIVE AS 2 SEPARATE 105 MG/1.17 ML PREFILLED SYRINGES. ROTATE SITE WITH EACH INJECTION.   | 210 mg | SC (upper arm, upper thigh, or abdomen) | ONCE EVERY MONTH x 12 | 1 Year   |

**LAB ORDERS: Calcium, BUN, Serum Creatinine, will be drawn prior to administration if previous results not provided within 30 days of appointment.**

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

- 1) **OSTEOPOROSIS / OSTEOPENIA:**
  - CALCIUM, BUN, AND SERUM CREATININE MUST BE CHECKED WITHIN THE LAST 30 DAYS OF THE APPOINTMENT
  - ORIGINAL BONE DENSITY/DEXA SCAN SUPPORTING THE DIAGNOSIS OF OSTEOPOROSIS OR OSTEOPENIA.
  - ORIGINAL 10 YEAR FRAX PROBABILITY SUPPORTING HIGH RISK FOR FUTURE FRACTURES (OSTEOPENIA DIAGNOSIS).
  - H+P OR OFFICE NOTES LISTING THE DIAGNOSIS OF OSTEOPOROSIS OR OSTEOPENIA IN THE PATIENT RECORD DATED WITHIN 1 YEAR PRIOR TO APPOINTMENT
  - PRIOR/CURRENT MEDICATIONS USED TO TREAT THE DIAGNOSIS OF OSTEOPOROSIS OR OSTEOPENIA 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 AN APPROVED DIAGNOSIS FOR RECLAST (ZOLEDRONIC ACID) WITH AN ASSOCIATION TO EITHER LOWER ENERGY FRACTURE (FRAGILITY FRACTURE) OR A HIGH RISK FOR FUTURE FRACTURES INDICATED BY THE PATIENTS 10 YEAR FRAX PROBABILITY.

\*OSTEOPENIA IS NOT AN APPROVED DIAGNOSIS FOR PROLIA (DENOSUMAB) OR EVENITY. PATIENTS WITH IMPRESSIONS OF OSTEOPENIA MUST HAVE AN ORIGINAL BONE DENSITY RESULT OR DEXA SCAN SUPPORTING THE DIAGNOSIS OF OSTEOPOROSIS OR DOCUMENTATION OF A LOWER ENERGY FRACTURE (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.

Physician's Signature \_\_\_\_\_ Time \_\_\_\_\_ Date \_\_\_\_\_

*\*Signature Must Be Clear and Legible*

Cosignature (If Required) \_\_\_\_\_ Time \_\_\_\_\_ Date \_\_\_\_\_

*\*Signature Must Be Clear and Legible*



**BH Infusion Clinic**  
 Phone: 270-580-2228  
 Fax: 877-249-1191

**STAT REFERRAL**

**BONE MARROW STIMULATING AGENTS ORDER FORM**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI \_\_\_\_\_ DOB: \_\_\_\_\_

HT: \_\_\_\_\_ in WT: \_\_\_\_\_  lbs  kg Sex:  Male  Female Allergies:  NKDA, \_\_\_\_\_

Physician 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**

Collect CBC prior to each injection (s) and fax results to Infusion Center

Hold erythropoietin injections if Hemoglobin is  $\geq$  to \_\_\_\_\_

| SELECT                   | MEDICATION                           | DOSE | ROUTE | FREQUENCY | DURATION |
|--------------------------|--------------------------------------|------|-------|-----------|----------|
| <input type="checkbox"/> | Aranesp                              |      |       |           |          |
| <input type="checkbox"/> | Neulasta                             |      |       |           |          |
| <input type="checkbox"/> | Neupogen (Granix Substitute)         |      |       |           |          |
| <input type="checkbox"/> | Procrit ESRD (Patients on Dialysis)  |      |       |           |          |
| <input type="checkbox"/> | Procrit NON ESRD                     |      |       |           |          |
| <input type="checkbox"/> | Retacrit ESRD (Patients on Dialysis) |      |       |           |          |
| <input type="checkbox"/> | Retacrit NON ESRD                    |      |       |           |          |
| <input type="checkbox"/> | Other:                               |      |       |           |          |

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*

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



**STAT REFERRAL**

**ASTHMA AGENTS**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI \_\_\_\_\_ DOB: \_\_\_\_\_

HT: \_\_\_\_\_ in WT: \_\_\_\_\_  lbs  kg Sex:  Male  Female Allergies:  NKDA, \_\_\_\_\_

Physician 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) \_\_\_\_\_

| SELECT                   | MEDICATION                  | DOSE   | ROUTE | FREQUENCY                                     | DURATION |
|--------------------------|-----------------------------|--|-------|---|----------|
| <input type="checkbox"/> | XOLAIR                      | <input type="checkbox"/> 150 mg<br><input type="checkbox"/> 225 mg<br><input type="checkbox"/> 300 mg<br><input type="checkbox"/> 375 mg | SQ    | Every _____ days                              |          |
| <input type="checkbox"/> | FASENRA (LOADING DOSES)     | 30 mg  | SQ    | Every 4 weeks for 3 doses, then every 8 weeks |          |
| <input type="checkbox"/> | FASENRA (MAINTENANCE DOSES) | 30 mg  | SQ    | Every 8 weeks                                 |          |
| <input type="checkbox"/> | NUCALA                      | 100 MG   | SQ    | Every 4 weeks                                 |          |
| <input type="checkbox"/> | TEZSPIRE                    | 210 mg   | SQ    | Every 4 weeks                                 |          |

**PREMEDS**

| SELECT                   | MEDICATION    | DOSE | ROUTE |
|--------------------------|---------------|------|-------|
| <input type="checkbox"/> | NONE          | NA   | NA    |
| <input type="checkbox"/> | BENADRYL      |      |       |
| <input type="checkbox"/> | ACETAMINOPHEN |      |       |
| <input type="checkbox"/> | OXYGEN        |      |       |
| <input type="checkbox"/> | Other:        |      |       |
| <input type="checkbox"/> | Other:        |      |       |
| <input type="checkbox"/> | Other:        |      |       |

**LABS**

| SELECT                   | LAB REQUESTED  | WHEN   | FREQUENCY |
|--------------------------|----------------|--|-----------|
| <input type="checkbox"/> | NONE           | NA   | NA        |
| <input type="checkbox"/> | BMP            | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |           |
| <input type="checkbox"/> | CMP            | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |           |
| <input type="checkbox"/> | BUN/CREATININE | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |           |
| <input type="checkbox"/> | CRP:           | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |           |
| <input type="checkbox"/> | ESR:           | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |           |
| <input type="checkbox"/> | Other:         | <input type="checkbox"/> PRIOR <input type="checkbox"/> 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

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



**RHEUMATOLOGY ORDER FORM**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI \_\_\_\_\_ DOB: \_\_\_\_\_

HT: \_\_\_\_\_ in WT: \_\_\_\_\_  lbs  kg Sex:  Male  Female Allergies:  NKDA, \_\_\_\_\_

Physician 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 MEDIPOINTS / IV ACCESSSES WILL BE FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL POLICY

b) ALL PRODUCTS WILL BE PREPARED AND ADMINISTERED FOLLOWING HOSPITAL POLICY

c) 500 mL BAG OF 0.9% NS MAY BE HUNG AT KVO RATE

IF LOADING DOSES HAVE BEEN INITIATED, LIST DOSE IN CYCLE TO BE GIVEN: \_\_\_\_\_

| Select                   | MEDICATION  | DOSE                       | ROUTE | FREQUENCY  | DURATION |
|--------------------------|---|----------------------------|-------|--|----------|
| <input type="checkbox"/> | ACTEMRA   | ____ MG / ____ KG= ____ MG |       | EVERY ____ WEEKS   |          |
| <input type="checkbox"/> | BENLYSTA LOADING DOSES  | 10 MG / ____ KG= ____ MG   | IV    | 0, 2, 4 WEEKS, THEN ONCE EVERY 4 WEEKS   |          |
| <input type="checkbox"/> | BENLYSTA MAINTENANCE DOSES  | 10 MG / ____ KG= ____ MG   | IV    | ONCE EVERY 4 WEEKS   |          |
| <input type="checkbox"/> | BENLYSTA MAINTENANCE DOSES  | 200 mg                     | SC    | ONCE WEEKLY  |          |
| <input type="checkbox"/> | INFLECTRA LOADING DOSES   | ____ MG / ____ KG= ____ MG | IV    | 0, 2, 6 WEEKS, THEN ONCE EVERY ____ WEEKS  |          |
| <input type="checkbox"/> | INFLECTRA MAINTENANCE DOSES   | ____ MG / ____ KG= ____ MG | IV    | ONCE EVERY ____ WEEKS<br>RATE: <input type="checkbox"/> RAPID or <input type="checkbox"/> STANDARD |          |
| <input type="checkbox"/> | KRYSTEXXA   | 8 mg                       | IV    | ONCE EVERY 2 WEEKS   |          |
| <input type="checkbox"/> | ORENCIA (LOADING DOSES)   | ____ mg                    | IV    | 0, 2, 4 WEEKS, THEN ONCE EVERY 4 WEEKS   |          |
| <input type="checkbox"/> | ORENCIA MAINTENANCE DOSES   | 500 mg                     | IV    | EVERY 4 WEEKS  |          |
| <input type="checkbox"/> | ORENCIA MAINTENANCE DOSES   | 750 mg                     | IV    | EVERY 4 WEEKS  |          |
| <input type="checkbox"/> | ORENCIA MAINTENANCE DOSES   | 1000 mg                    | IV    | EVERY 4 WEEKS  |          |
| <input type="checkbox"/> | REMICADE LOADING DOSES  | ____ MG / ____ KG= ____ MG | IV    | 0, 2, 6 WEEKS, THEN ONCE EVERY ____ WEEKS  |          |
| <input type="checkbox"/> | REMICADE MAINTENANCE DOSES  | ____ MG / ____ KG= ____ MG | IV    | ONCE EVERY ____ WEEKS<br>RATE: <input type="checkbox"/> RAPID or <input type="checkbox"/> STANDARD |          |
| <input type="checkbox"/> | RITUXAN   | ____ MG / ____ KG= ____ MG | IV    | EVERY ____ WEEKS   |          |
| <input type="checkbox"/> | SIMPONI ARIA  | ____ MG / ____ KG= ____ MG | IV    | EVERY ____ WEEKS   |          |
| <input type="checkbox"/> | Stelara Loading Dose(s)<br>*SC administration is NOT covered Outpatient | _____mg                    | IV    | Once   | 1        |

**PREMEDS**

| SELECT                   | MEDICATION    | DOSE | ROUTE |
|--------------------------|---------------|------|-------|
| <input type="checkbox"/> | NONE          | NA   | NA    |
| <input type="checkbox"/> | BENADRYL      |      |       |
| <input type="checkbox"/> | ACETAMINOPHEN |      |       |
| <input type="checkbox"/> | OXYGEN        |      |       |
| <input type="checkbox"/> | SOLU-MEDROL   |      |       |
| <input type="checkbox"/> | ONDANSETRON   |      |       |
| <input type="checkbox"/> | FAMOTIDINE    |      |       |
| <input type="checkbox"/> | Other:        |      |       |
| <input type="checkbox"/> | Other:        |      |       |
| <input type="checkbox"/> | Other:        |      |       |

**LABS**

| SELECT                   | LAB REQUESTED  | WHEN | FREQUENCY |
|--------------------------|----------------|------|-----------|
| <input type="checkbox"/> | NONE           | NA   | NA        |
| <input type="checkbox"/> | BMP            |      |           |
| <input type="checkbox"/> | CMP            |      |           |
| <input type="checkbox"/> | BUN/CREATININE |      |           |
| <input type="checkbox"/> | CRP            |      |           |
| <input type="checkbox"/> | ESR            |      |           |
| <input type="checkbox"/> | ALT            |      |           |
| <input type="checkbox"/> | AST            |      |           |
| <input type="checkbox"/> | LIVER PANEL    |      |           |
| <input type="checkbox"/> | OTHER:         |      |           |

Physician's Signature \_\_\_\_\_ Time \_\_\_\_\_ Date \_\_\_\_\_  
 \*Signature Must Be Legible

Cosignature (If Required) \_\_\_\_\_ Time \_\_\_\_\_ Date \_\_\_\_\_  
 \*Signature Must Be Legible



**IRON PRODUCTS ORDER FORM**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI \_\_\_\_\_ DOB: \_\_\_\_\_

HT: \_\_\_\_\_ in WT: \_\_\_\_\_  lbs  kg Sex:  Male  Female Allergies:  NKDA, \_\_\_\_\_

Physician 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 MEDIPOINTS/IV ACCESS WILL BE ACCESSED AND FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL POLICY
- b) ALL PRODUCTS WILL BE PREPARED AND ADMINISTERED FOLLOWING HOSPITAL POLICY
- c) SUPPORTING LABWORK AND DOCUMENTATION OF ORAL IRON TREATMENT MAY BE REQUIRED BASED ON INDIVIDUAL PAYOR GUIDELINES

| SELECT                   | MEDICATION | DOSE   | ROUTE | FREQUENCY                          | DURATION |
|--------------------------|------------|--------|-------|------------------------------------|----------|
| <input type="checkbox"/> | VENOFER    | ____mg | IV    |                                    |          |
| <input type="checkbox"/> | VENOFER    | 200 mg | IV    | ONCE EVERY WEEK                    | 5 Doses  |
| <input type="checkbox"/> | INJECTAFER | 750 mg | IV    | ONCE EVERY WEEK                    | 2 Weeks  |
| <input type="checkbox"/> | FERRLECIT  | 125 mg | IV    |                                    |          |
| <input type="checkbox"/> | FERRLECIT  | 250 mg | IV    |                                    |          |
| <input type="checkbox"/> | FERAHEME   | 510 mg | IV    | ONCE, THEN REPEAT 3 – 8 DAYS LATER | 2 Doses  |
| <input type="checkbox"/> | OTHER:     |        |       |                                    |          |

**PREMEDS**

| SELECT                   | MEDICATION    | DOSE          | ROUTE |
|--------------------------|---------------|---------------|-------|
| <input type="checkbox"/> | NONE          | NA            | NA    |
| <input type="checkbox"/> | BENADRYL      | 50 mg         | IV    |
| <input type="checkbox"/> | ACETAMINOPHEN |               |       |
| <input type="checkbox"/> | OXYGEN        |               |       |
| <input type="checkbox"/> | EPINEPHRINE   | 0.3mg / 0.3mL | IM    |
| <input type="checkbox"/> | SOLU-MEDROL   | 125 mg        | IV    |
| <input type="checkbox"/> | Other:        |               |       |

**LABS**

| SELECT BELOW             | LAB REQUESTED  | WHEN   | FREQUENCY |
|--------------------------|----------------|--|-----------|
| <input type="checkbox"/> | NONE           | NA   | NA        |
| <input type="checkbox"/> | BMP            | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |           |
| <input type="checkbox"/> | CMP            | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |           |
| <input type="checkbox"/> | BUN/CREATININE | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |           |
| <input type="checkbox"/> | H+H:           | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |           |
| <input type="checkbox"/> | Ferritin:      | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |           |
| <input type="checkbox"/> | Other:         | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |           |

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.**




**THERAPEUTIC PHLEBOTOMY ORDER FORM**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI \_\_\_\_\_ DOB: \_\_\_\_\_

HT: \_\_\_\_\_ in WT: \_\_\_\_\_  lbs  kg Sex:  Male  Female Allergies:  NKDA, \_\_\_\_\_

Physician 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 MEDIPOINTS / IV ACCESSES WILL BE FLUSHED WITH HEPARIN OR SALINE PER HOSPITAL POLICY PRN
- b) 10 mL NS Flush Syringe PRN
- c) ORDERS WITH INCOMPLETE PARAMETERS WILL NOT BE SERVICED

| TREATMENT              | mL TO REMOVE (+/- 50 mL) | PARAMATERS      | FREQUENCY   | DURATION |
|------------------------|--------------------------|-----------------|---|----------|
| Therapeutic Phlebotomy |                          | HOLD if ≤ _____ | <input type="checkbox"/> 1 x only<br><input type="checkbox"/> Weekly<br><input type="checkbox"/> Monthly<br><input type="checkbox"/> Other: |          |

| LABS                     |                |                          | NOTES/INSTRUCTIONS/OTHER |
|--------------------------|----------------|--------------------------|--------------------------|
| SELECT                   | LAB REQUESTED  | FREQUENCY                |                          |
| <input type="checkbox"/> | NONE           | NA                       |                          |
| <input type="checkbox"/> | CBC w/ Diff    | PRIOR TO EACH PHLEBOTOMY |                          |
| <input type="checkbox"/> | Hgb            | PRIOR TO EACH PHLEBOTOMY |                          |
| <input type="checkbox"/> | Hct            | PRIOR TO EACH PHLEBOTOMY |                          |
| <input type="checkbox"/> | BMP            |                          |                          |
| <input type="checkbox"/> | CMP            |                          |                          |
| <input type="checkbox"/> | BUN/CREATININE |                          |                          |
| <input type="checkbox"/> | ESR            |                          |                          |
| <input type="checkbox"/> | CRP            |                          |                          |
| <input type="checkbox"/> | CPK            |                          |                          |
| <input type="checkbox"/> | Ferritin       |                          |                          |
| <input type="checkbox"/> | Other:         |                          |                          |
| <input type="checkbox"/> | 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.**




**HEADACHE ORDER FORM**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI \_\_\_\_\_ DOB: \_\_\_\_\_

HT: \_\_\_\_\_ in WT: \_\_\_\_\_  lbs  kg Sex:  Male  Female Allergies:  NKDA, \_\_\_\_\_

Physician 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  MEDIPOINT  PIV  PICC LINE  OTHER: \_\_\_\_\_

**PRESCRIPTION ORDERS**

| SELECT                   | MEDICATION         | DOSE   | ROUTE | FREQUENCY           | DURATION |
|--------------------------|--------------------|--------|-------|---------------------|----------|
| <input type="checkbox"/> | BENADRYL           |        |       |                     |          |
| <input type="checkbox"/> | COMPAZINE          |        |       |                     |          |
| <input type="checkbox"/> | DEPAACON           |        |       |                     |          |
| <input type="checkbox"/> | DHE 45             |        |       |                     |          |
| <input type="checkbox"/> | DILANTIN           |        |       |                     |          |
| <input type="checkbox"/> | KEPPRA             |        |       |                     |          |
| <input type="checkbox"/> | KETOROLAC          |        |       |                     |          |
| <input type="checkbox"/> | METHYLPREDNISOLONE |        |       |                     |          |
| <input type="checkbox"/> | METOCLOPRAMIDE     |        |       |                     |          |
| <input type="checkbox"/> | ORPHENADRINE       |        |       |                     |          |
| <input type="checkbox"/> | PROMETHAZINE       |        |       |                     |          |
| <input type="checkbox"/> | VYEPTI             | 100 mg | IV    | Once Every 3 Months |          |
| <input type="checkbox"/> | 0.9% NS            |        |       |                     |          |

**PREMEDS**

| SELECT                   | MEDICATION    | DOSE | ROUTE |
|--------------------------|---------------|------|-------|
| <input type="checkbox"/> | NONE          | NA   | NA    |
| <input type="checkbox"/> | BENADRYL      |      | IV    |
| <input type="checkbox"/> | ACETAMINOPHEN |      |       |
| <input type="checkbox"/> | OXYGEN        |      |       |
| <input type="checkbox"/> | ZOFRAN        |      | IV    |
| <input type="checkbox"/> | Other:        |      |       |
| <input type="checkbox"/> | Other:        |      |       |

**LABS**

| SELECT                   | LAB REQUESTED  | WHEN   | FREQUENCY |
|--------------------------|----------------|--|-----------|
| <input type="checkbox"/> | NONE           | NA   | NA        |
| <input type="checkbox"/> | BMP            | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |           |
| <input type="checkbox"/> | CMP            | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |           |
| <input type="checkbox"/> | BUN/CREATININE | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |           |
| <input type="checkbox"/> | CRP:           | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |           |
| <input type="checkbox"/> | ESR:           | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |           |
| <input type="checkbox"/> | Other:         | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |           |

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

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



**ANTIBIOTICS ORDER FORM**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI \_\_\_\_\_ DOB: \_\_\_\_\_

HT: \_\_\_\_\_ in WT: \_\_\_\_\_  lbs  kg Sex:  Male  Female Allergies:  NKDA, \_\_\_\_\_

Physician 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  OTHER: \_\_\_\_\_

**PICC LINE INSTRUCTIONS MUST BE SELECTED (Check the option):**  D/C PICC AFTER LAST DOSE  PERFORM LINE CARE PER HOSPITAL POLICY UNTIL LINE IS REMOVED

- a) ALL MEDIPOINTS/IV ACCESSES MAY BE FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL POLICY
- b) HOSPITAL PHARMACY WILL FOLLOW AND ADJUST DOSING FOR VANCOMYCIN, GENTAMICIN, AND MAY INTERVENE PER HOSPITAL POLICY FOR PATIENT SAFETY

| SELECT                   | DRUG                   | DOSE    | ROUTE   | REPEAT EVERY | DURATION |
|--------------------------|------------------------|---------|---|--------------|----------|
| <input type="checkbox"/> | Vancomycin             | 500 mg  | IV  |              |          |
| <input type="checkbox"/> | Vancomycin             | 750 mg  | IV  |              |          |
| <input type="checkbox"/> | Vancomycin             | 1000 mg | IV  |              |          |
| <input type="checkbox"/> | Vancomycin             | 1500 mg | IV  |              |          |
| <input type="checkbox"/> | Vancomycin             | 1750 mg | IV  |              |          |
| <input type="checkbox"/> | Vancomycin             | 2000 mg | IV  |              |          |
| <input type="checkbox"/> | Rocephin (Ceftriaxone) | 250 mg  | <input type="checkbox"/> IV <input type="checkbox"/> IM |              |          |
| <input type="checkbox"/> | Rocephin (Ceftriaxone) | 500 mg  | <input type="checkbox"/> IV <input type="checkbox"/> IM |              |          |
| <input type="checkbox"/> | Rocephin (Ceftriaxone) | 750 mg  | <input type="checkbox"/> IV <input type="checkbox"/> IM |              |          |
| <input type="checkbox"/> | Rocephin (Ceftriaxone) | 1000 mg | <input type="checkbox"/> IV <input type="checkbox"/> IM |              |          |
| <input type="checkbox"/> | Rocephin (Ceftriaxone) | 2000 mg | <input type="checkbox"/> IV <input type="checkbox"/> IM |              |          |
| <input type="checkbox"/> | Invanz (Ertapenem)     | 500 mg  | <input type="checkbox"/> IV <input type="checkbox"/> IM |              |          |

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

**OTHER MEDICATION (not listed):**

| SELECT                   | LAB REQUESTED  | WHEN   | FREQUENCY |
|--------------------------|----------------|--|-----------|
| <input type="checkbox"/> | NONE           | NA   | NA        |
| <input type="checkbox"/> | BMP            | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |           |
| <input type="checkbox"/> | CMP            | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |           |
| <input type="checkbox"/> | BUN/CREATININE | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |           |
| <input type="checkbox"/> | CRP            | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |           |
| <input type="checkbox"/> | ESR            | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |           |
| <input type="checkbox"/> | ALT            | PRIOR  |           |
| <input type="checkbox"/> | VANCO TROUGH   |  |           |
| <input type="checkbox"/> | GENT TROUGH    |  |           |

| SELECT                   | LAB REQUESTED | WHEN   | FREQUENCY |
|--------------------------|---------------|--|-----------|
| <input type="checkbox"/> | CK            | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |           |
| <input type="checkbox"/> | UA            | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |           |
| <input type="checkbox"/> | Other:        | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |           |
| <input type="checkbox"/> | Other:        | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |           |
| <input type="checkbox"/> | Other:        | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |           |
| <input type="checkbox"/> | Other:        | <input type="checkbox"/> PRIOR <input type="checkbox"/> POST |           |
| <input type="checkbox"/> | Other:        |  |           |
| <input type="checkbox"/> | Other:        |  |           |
| <input type="checkbox"/> | 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*

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



**STAT REFERRAL**

**LEQEMBI ORDER FORM**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI \_\_\_\_\_ DOB: \_\_\_\_\_

HT: \_\_\_\_\_ in WT: \_\_\_\_\_  lbs  kg Sex:  Male  Female Allergies:  NKDA, \_\_\_\_\_

Physician 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 HEPARIN OR SALINE PER HOSPITAL PROTOCOL PRN

**PLEASE SELECT FROM BELOW:**

- \_\_\_\_\_ Perform port flush every \_\_\_\_\_ weeks per hospital policy.
- \_\_\_\_\_ 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
  - Other: \_\_\_\_\_ (ICD 10 + Description)
- ← G30.X codes require secondary F02.8X code →
- F02.80 Dementia without behavioral disturbance
  - F02.81 Dementia with behavioral disturbance

**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
- CMS Alzheimer National Patient Registry Number: ALZH - \_\_\_\_\_  National Clinical Trial Number: NCT - \_\_\_\_\_

**PRESCRIPTION ORDERS**

|                |                 |                                    |   |                  |
|----------------|-----------------|------------------------------------|---|------------------|
| <b>Leqembi</b> | <b>10 mg/kg</b> | <b>IV Over At Least 60 Minutes</b> | <b>Every 2 Weeks</b><br><i>(at least 14 days apart)</i> | <b>12 Months</b> |
| <b>DRUG</b>    | <b>DOSE</b>     | <b>ROUTE</b>                       | <b>FREQUENCY</b>  | <b>DURATION</b>  |

**Pre-Infusion:**

- Confirm baseline MRI results prior to initiation of treatment.
- Confirm MRI completed and reviewed by prescriber prior to the 3rd, 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*

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



**KISUNLA ORDER FORM**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_ DOB: \_\_\_\_\_

HT: \_\_\_\_\_ in WT: \_\_\_\_\_  lbs  kg Sex:  Male  Female Allergies:  NKDA, \_\_\_\_\_

Physician 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 HEPARIN OR SALINE PER HOSPITAL PROTOCOL PRN

**PLEASE SELECT FROM BELOW:**

- \_\_\_\_\_ Perform port flush every \_\_\_\_\_ weeks per hospital policy.
- \_\_\_\_\_ 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
  - Other: \_\_\_\_\_ (ICD 10 + Description)
- ← G30.X codes require secondary F02.8X code →
- F02.80 Dementia without behavioral disturbance
  - F02.81 Dementia with behavioral disturbance

**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
- CMS Alzheimer National Patient Registry Number: ALZH - \_\_\_\_\_  National Clinical Trial Number: NCT - \_\_\_\_\_

**PRESCRIPTION ORDERS**

| SELECT                   | DRUG    | TITRATED DOSING | ROUTE                       | TITRATED SCHEDULE   | DURATION  |
|--------------------------|---------|-----------------|-----------------------------|---|-----------|
| <input type="checkbox"/> | Kisunla | 350 mg          | IV Over At Least 30 Minutes | Infusion 1  | 1 time    |
| <input type="checkbox"/> | Kisunla | 700 mg          | IV Over At Least 30 Minutes | Infusion 2<br>(4 weeks after infusion 1)  | 1 time    |
| <input type="checkbox"/> | Kisunla | 1050 mg         | IV Over At Least 30 Minutes | Infusion 3<br>(4 weeks after infusion 2)  | 1 time    |
| <input type="checkbox"/> | Kisunla | 1400 mg         | IV Over At Least 30 Minutes | Infusion 4 and Beyond<br>(4 weeks after infusion 3 and then every 4 weeks thereafter) | 12 Months |

**Pre-Infusion:**

- Confirm baseline MRI results prior to initiation of treatment.
- Confirm MRI completed and reviewed by prescriber prior to the 2nd, 3rd, 4th and 7th 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

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




**ACTH STIMULATION TEST ORDER FORM**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_ DOB: \_\_\_\_\_

HT: \_\_\_\_\_ in WT: \_\_\_\_\_  lbs  kg Sex:  Male  Female Allergies:  NKDA, \_\_\_\_\_

Physician 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 HEPARIN OR SALINE PER HOSPITAL POLICY PRN

| SELECT                   | MEDICATION                    | DOSE | ROUTE                  | FREQUENCY | DURATION |
|--------------------------|-------------------------------|------|------------------------|-----------|----------|
| <input type="checkbox"/> | COSYNTROPIN 250 MCG/2 mL (NS) | 2 mL | IV Push over 2 minutes | ONCE      | 1        |

**LABS**

**NOTES/INSTRUCTIONS/OTHER**

| SELECT                   | LAB REQUESTED  | FREQUENCY                                      | NOTES/INSTRUCTIONS/OTHER |
|--------------------------|----------------|--|--------------------------|
| X                        | ACTH LEVEL     | PRIOR  |                          |
| X                        | CORTISOL LEVEL | PRIOR AND REPEAT 30 + 60 MINUTES POST INFUSION |                          |
| <input type="checkbox"/> | Other:         |  |                          |
| <input type="checkbox"/> | Other:         |  |                          |
| <input type="checkbox"/> | Other:         |  |                          |

- 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
- Flush line with 10 mL 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

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



**LEQVIO ORDER FORM**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_ DOB: \_\_\_\_\_

HT: \_\_\_\_\_ in WT: \_\_\_\_\_  lbs  kg Sex:  Male  Female Allergies:  NKDA, \_\_\_\_\_

Physician 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 MEDIPOINTS / IV ACCESSES WILL BE FLUSHED WITH HEPARIN OR SALINE PER HOSPITAL POLICY PRN
- b) ALL PRODUCTS WILL BE PREPARED AND ADMINISTERED FOLLOWING HOSPITAL POLICY

| SELECT                   | MEDICATION                 | DOSE   | ROUTE | FREQUENCY                          | DURATION |
|--------------------------|----------------------------|--------|-------|------------------------------------|----------|
| <input type="checkbox"/> | LEQVIO (LOADING DOSES)     | 284 mg | SQ    | Month 0 and 3, then every 6 months |          |
| <input type="checkbox"/> | LEQVIO (MAINTENANCE DOSES) | 284 mg | SQ    | Every 6 months                     |          |

**LABS**

| SELECT                   | LAB REQUESTED | FREQUENCY |
|--------------------------|---------------|-----------|
| <input type="checkbox"/> |               |           |
| <input type="checkbox"/> |               |           |

**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  $\geq$  190MG/DL ( $\geq$  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 2<sup>ND</sup> 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  $\geq$  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  $\geq$  8 CONTINUOUS WEEKS?  YES  NO
- 7) INDICATE ANY CONDITIONS THE PATIENT HAS:
  - ACUTE CORONARY SYNDROME  HISTORY OF MYOCARDIAL INFARCTION
  - CORONARY OR OTHER ARTERIAL REVASCULARIZATION  TRANSIENT ISCHEMIC ATTACK
  - PERIPHERAL ARTERIAL DISEASE PRESUMED TO BE OF ATHEROSCLEROTIC ORIGIN  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



**STAT REFERRAL**

**SPRAVATO ORDER FORM**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_ DOB: \_\_\_\_\_

HT: \_\_\_\_\_ in WT: \_\_\_\_\_  lbs  kg Sex:  Male  Female Allergies:  NKDA, \_\_\_\_\_

Physician 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**

Depression Severity Score: \_\_\_\_\_ Date: \_\_\_\_\_

Rating Scale Used: \_\_\_\_\_

(e.g., Beck Depression Inventory [BDI], Hamilton Depression Rating Scale [HDRS], Montgomery-Asberg Depression Rating Scale [MADRS], etc.)

**PRESCRIPTION ORDERS**

| SELECT                   | MEDICATION                   | DOSE  | ROUTE       | FREQUENCY                              | DURATION |
|--------------------------|------------------------------|-------|-------------|--|----------|
| <input type="checkbox"/> | Spravato Induction Dose(s)   | 56 mg | Nasal Spray | Twice Every Week (Weeks 1-4)           | 4 Weeks  |
| <input type="checkbox"/> | Spravato Induction Dose(s)   | 84 mg | Nasal Spray | Twice Every Week (Weeks 1-4)           | 4 Weeks  |
| <input type="checkbox"/> | Spravato Maintenance Dose(s) | 56 mg | Nasal Spray | Once Every Week (Weeks 5-8)            | 4 Weeks  |
| <input type="checkbox"/> | Spravato Maintenance Dose(s) | 84 mg | Nasal Spray | Once Every Week (Weeks 5-8)            | 4 Weeks  |
| <input type="checkbox"/> | Spravato Maintenance Dose(s) | 56 mg | Nasal Spray | Once Every 2 Weeks (Weeks 9 and after) |          |
| <input type="checkbox"/> | Spravato Maintenance Dose(s) | 84 mg | Nasal Spray | Once Every 2 Weeks (Weeks 9 and after) |          |
| <input type="checkbox"/> | Spravato Maintenance Dose(s) | 56 mg | Nasal Spray | Once Every Week (Weeks 9 and after)    |          |
| <input type="checkbox"/> | Spravato Maintenance Dose(s) | 84 mg | Nasal Spray | Once Every Week (Weeks 9 and after)    |          |

**SUPPORTING DOCUMENTATION FOR PATIENTS RECEIVING SPRAVATO:**

- 1) **Treatment-Resistant Depression (TRD)**
  - Patients have a confirmed diagnosis of severe major depressive disorder (single or recurrent episode), documented by standardized rating scales that reliably measure depressive symptoms.
  - Patients have experienced inadequate response during the current depressive episode with two antidepressants from at least two different classes with different mechanisms of action at the maximally tolerated labeled dose, each used for at least 8 weeks within the past 5 years.
  - Patients have experienced an inadequate response with an adequate trial of augmentation therapy for at least 8 weeks within the past 5 years or evidenced based psychotherapy.
- 2) **Major Depressive Disorder (MDD) with acute suicidal ideation or behavior**
  - Patients have major depressive disorder with current suicidal ideation with intent.
  - The prescriber must present in the clinical documentation that, in the absence of the requested drug, within the next 24 to 48 hours the patient will require confinement in an acute care psychiatric institution; and the requested medication will be used in combination with an oral antidepressant.

\*Provider must enroll patient in the SPRAVATO REMS Program and provide enrollment confirmation documentation.

\*This medication must be prescribed by or in consultation with a psychiatrist

\*Spravato nasal spray is considered an exclusion for members with moderate or severe substance or alcohol use disorder that is not currently being treated or medically managed.

\*Augmentation therapy is defined as: two antidepressants with different mechanisms of action used concomitantly, an antidepressant and a second-generation antipsychotic used concomitantly, an antidepressant and lithium used concomitantly, or an antidepressant and thyroid hormone used concomitantly.

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.**