

Fax: 1-877-249-1191

HOW TO MAKE A REFERRAL

Referrals can be made 24 hours a day, 7 days a week! All referrals will be processed promptly, day or night, by our dedicated case managers. We look forward to treating your patients with the highest level of care and appreciate your choice to use *CONNALLY MEMORIAL INFUSION CENTER*.

Steps for Referring a Patient for Outpatient Infusion Therapy

- 1. Use the, Infusion Center, "IV Infusion Order Form"
- 2. Complete all required information or submit along with a facesheet *(If you do not complete the form and the information is not present on the facesheet, you will receive a telephone call in order to obtain required information)
- 3. Fax "IV Infusion Order Form" with all appropriate Patient information to the toll-free fax number, <u>877-249-1191</u>, also on the bottom of the "<u>IV Infusion</u> <u>Order Form</u>"
- 4. Call Case Management at <u>830-477-0424</u> to notify the infusion center case manager
- 5. The patient's benefits will be verified and the appointment will be scheduled

*ALL STAT/URGENT REFERRALS WILL RECEIVE IMMEDIATE ATTENTION. PLEASE CALL 830-477-0424 TO NOTIFY CASE MANAGEMENT TO EXPEDITE THE PROCESS

<u>CONNALLY MEMORIAL INFUSION CENTER</u> looks forward to treating your Patients with the highest standards for IV infusion therapy.



Fax: 1-877-249-1191

PARTIAL MEDICATION LIST

• Actemra

Albumin

• Amikacin

Ancef

Aranesp

Azactam

Bactrim

Benlysta

Cefazolin

• Cimzia

Ciprofloxacin

Cleocin

Dalvance

Daptomycin

• DHE 45

Enbrel

Fasenra

Ferrlecit

Flagyl

Fortaz

• Ganciclovir

• Gentamicin

• Humira

Inflectra

Invanz

Injectafer

• IVIG

Keflex

• Levaquin

Lupron

• Merrem

• Methylprednisolone

• Mycamine

• Neulasta

Neupogen

• Nucala

• Ocrevus

• Orbativ

• Orencia

• Penicllin

• Procrit

• Prolia

• Radicava

Reclast

• Remicade

Renflexis

• Rifampin

• Rituxan

• Rocephin

• Simponi

• Soliris

• Teflaro

• Tobramycin

• Tycagil

• Tysabri

• Vancomycin

• Venofer

• Xolair

Zometa

Zyvox



STAT REFERRAL

BLOOD PRODUCT TRANSFUSION ORDER FORM

<u>PATI</u>	ENT INFORMATION								
	Name:						M		
							(
Addre	ess			City/Sta	ate/Zip _				
•	gies:								
							y ID #:		
							y ID #:		
							Contact Phone #		
	ess:								
			Tax ID#:_				Fax #:		
	FEMENT OF MEDICAL NECE								
Prim	ary Diagnosis: (ICD 10 CO	DE + DESCRIPTION)			Secon	dary Diagno	osis: (ICD 10 CODE + DESC	CRIPTION)	
	TINENT MEDICAL HISTORY	□ VEC □ NO 15		MEDIDORT [DICCLIN	NE OTHER:		
	the patient incontinent?						NE UTHER:		
,	•	Tres O No 2) is the	patient am	bulatory? O res	O NO	1			
	ES:	AULL DE AOOFOOFD AND	FLUQUEDV	WITH OAL ING OR LIE	DADIN F	NED LICODIT	AL DROTOGOL DDN		
	LL MEDIPORTS / IV ACCESS \ 50 cc BAG OF 0.9% NS MAY B				PARIN F	'ER HOSPII	AL PROTOCOL PRN		
- /	JBING WILL BE FLUSHED WI								
,	+H MUST BE COMPLETED W		OINITIATIO	N OF ALL BLOOD P	RODUC		IONS		
I YPE	E, CROSSMATCH, AND TRAN # of UNITS	ISFUSE:	PRODUCT			LABS SELECT	LAB REQUESTED)	WHEN
ELECT	# OI UNITS	FRESH FROZEN PLASI					NONE		NA
							BMP		() PRIOR () POST
		LEUKO REDUCED PRB					CMP		()PRIOR ()POST
		LEUKO REDUCED IRRA	ADITED PRE	Cs					
		LEUKO REDUCED PLA	TELETS				CBC w/ DIFF		() PRIOR () POST
		LEUKO REDUCED IRRA	ADIATED PL	ATELETS			H+H:		() PRIOR () POST
		Other:					Other:		() PRIOR () POST
PRFI	MEDS					NOTES/II	NSTRUCTIONS/COMMENTS		
LECT	MEDICATION	DOSE	ROUTE	FREQUENCY		NO I LO/II	to incommento		
	NONE	NA	NA	NA					
	BENADRYL								
	ACETAMINOPHEN								
	OXYGEN								
	LASIX	20mg	IV						
	Other:								
	l		1						
DIE	TARY RESTRICTIONS (If none, please indic	ate):						
						221			
FLU	SHES: L 10 mL NS Flu	sh Syringe PRN	Heparin 5	00 units/5 mL Flu	sh Syri	nge PRN	DO NOT ADMINISTE	R HEPARIN TO	THIS PATIENT
Phys	sician's Signature	,					_Time	Date	
*Sign	nature Must Be Clear and Legib	le							
	ignature (If Required)						_Time	Date	
*Sign	nature Must Be Clear and Legib	le							



STAT	REFERI	RAL

ENTYVIO (VEDOLIZUMAB) ORDER FORM

<u>PATIEI</u>	NT INFORMATION									
	ime:									
	in WT:kg Sex									
Addres	3			City/State/Zip						
Allergie	s:									
Primary	Insurance Name				_ Policy ID #:					
	ary Insurance Name									
	an Name									
	s:									
NPI#:		Tax ID#:			Fax #: _					
STATE	MENT OF MEDICAL NECESSITY									
	y Diagnosis: ICD-10 Code plus D	escription:								
PERTI	PERTINENT MEDICAL HISTORY 1) TB test performed? O Yes O No Date: Results,									
2) Patio	ent diagnosed with Congestive Heart F	Failure? O Ves O No 3) Liv	or function to	et normal? O Vec O N	Jo					
,	ent previously treated with Entyvio? C	,) Vec O No Date:				
						7 Tes O No Date.				
	MEDIPORTS / IV ACCESSES WILL E YVIO (VEDOLIZUMAB) WILL BE ADI					ON FILTER				
	LINES WILL BE FLUSHED WITH 30				0.20	J. ()				
PRESC	RIPTION ORDERS: ENTYVIO (VED	OLIZUMAB)								
Does p	atient have venous access?	YES NO								
If ves.	what type: MEDIPORT	PIV PICC LINE	□ отн	IER:						
	<i>,</i>									
ELECT	DOSING OPTIONS	DOSE	ROUTE		FREQUENCY (POPULA	•	DURATION			
	LOADING DOSES	300 MG	IV	0, 2, 6 WEEKS, 1	HEN ONCE EVERY	8 WEEKS				
	MAINTENANCE DOSE	300 MG	IV	ONCE EVERY 8	WEEKS					
PREME	EDS			LABS						
ECT	MEDICATION	DOSE	ROUTE	SELECT	LAB REQUESTED	WHEN	FREQUENCY			
	NONE	NA	NA	NO	NE	NA	NA			
	BENADRYL			BM	P	() PRIOR () POST				
	ACETAMINOPHEN			CM	P	() PRIOR () POST				
	OXYGEN			BU	N/CREATININE	() PRIOR () POST				
						. , . , , ,				
	Other:			CR	P:	() PRIOR () POST				
	Other:			ES	R:	() PRIOR () POST				
-	Other:			Ott	ner:	() PRIOR () POST				
						() ()				
NOTES	/INSTRUCTIONS/COMMENTS									
FLUSI	IES: 🔲 10 mL NS Flush Syri	nge PRN 🔲 Heparin 5	00 units/5 r	nL Flush Syringe I	PRN DO NOT	ADMINISTER HEPARIN TO	THIS PATIENT			
Physic	cian's Signature				Time	Date				
	ure Must Be Clear and Legible				111116	Date				
	-				Times	Dat-				
*Signat	nature (If Required)_ ure Must Be Clear and Legible				Time	Date				



STAT	REFERI	RAL

GENERAL IV ORDER FORM

							_ MIDOB:	
							Cell#:	
-						·		
							ne #	
IPI#:			Tax ID#:			Fax #:		
TATEMENT	OF MEDICAL NECESS	<u>SITY</u>						
Primary Diagn	osis: (ICD 10 CODE + I	DESCRIPTIO	N)		Secondary D	iagnosis: (ICD 10 CODE + DI	ESCRIPTION)	
PRESCRIPTION ALL	<mark>ON ORDERS</mark> . MEDIPORTS / IV ACCES		FLUSHED WITH HEPARIN	OR SALII	NE PER HOSPITA	L PROTOCOL PRN	ER:	
-,			IITOR AND ADJUST THER e select: D/C AFTER			IVING VANCOMYCIN OR GENT Perform Daily/Weekly IV \$	TAMYCIN Bite Care PRN Until Discharged	
	DRUG 1		DOSE	1	ROUTE	FREQUENCY	DURATION	
	DRUG 2		DOSE		ROUTE	FREQUENCY	DURATION	
	DROG Z		DOOL		ROUTE	TREQUEROT	DOMATION	
	DRUG 3		DOSE	ROUTE		FREQUENCY	DURATION	
	DRUG 4		DOSE		ROUTE	FREQUENCY	DURATION	
.ABS			2002			UCTIONS/OTHER	Dorumon	
LECT BELOW	LAB REQUESTED		EDECITENCY			- Perform daily/weekly IV site care PRN until discharged		
	NONE	NA				critini dany, weekly 1 v si	ace care ran vanish assentinged	
	CBC w/ Diff				- A	dminister Cath-Flo Activ	ase 2mg IVP PRN if line beco	
	BMP				slı	uggish or occluded		
	CMP							
	BUN/CREATININE							
	FOR							
	ESR							
	CRP							
	CRP CPK							
	CRP CPK Other:							
	CRP CPK							
LUSHES: [CRP CPK Other:	yringe PRN	☐ Heparin 500 units	/5 mL FI	ush Syringe PR	RN DO NOT ADMINIS	STER HEPARIN TO THIS PATIEN	
	CRP CPK Other: Other:	yringe PRN	☐ Heparin 500 units	/5 mL FI	ush Syringe PF			
hysician's S	CRP CPK Other: Other: 10 mL NS Flush Sy	yringe PRN	☐ Heparin 500 units	/5 mL FI	ush Syringe PR	RN DO NOT ADMINIS	STER HEPARIN TO THIS PATIEN	
FLUSHES: [Physician's S Signature Must	CRP CPK Other: Other: 10 mL NS Flush Sy ignature Be Clear and Legible	yringe PRN	☐ Heparin 500 units	/5 mL FI	ush Syringe PF			



STAT REFERRAL

HYDRATION ORDER FORM

PATIENT INFOR	<u>rmation</u>						
Last Name:		First	Name:			MIDOB:	
HT:	in WT:kg Sex	:() Male () Female SSN:		Home#:		Cell#:	
Address			City	//State/Zip			
Allergies:							
Primary Insurance	ce Name			Polic	y ID #:		
Secondary Insur	ance Name			Polic	y ID #:		
Physician Name		Conta	ct Name Contact Phone #				
Address:			-				
NPI#:	F MEDICAL NECESSITY	Tax ID#:			Fax#:		
•						Date of Diagnosis:	
•		YES NO If yes, what typ WILL BE ACCESSED AND FLUSHED			_	OTHER:	
DO NOT ADMI	NISTER HEPARIN TO THIS	S PATIENT					
PRESCRIPT	ON ORDERS FOR H	YDRATION Select the f	uid requ	ested AND the corre	sponding rate bel	low	
1.) 🗆 NO F	RMAL SALINE	2.) 🗆 LAC	TATED RINGERS			
☐ 500 mls, IV	x		□ 500	mls, IV x			
□ 1000 mls (1	Liter), IV x		□ 1000 mls (1 Liter), IV x				
□ 2000 mls (2	Liters), IV x		□ 2000 mls (2 Liters), IV x				
RATE			RATE				
□ BOLUS - GI	VEN OVER 1 HOUR		□ BOLUS - GIVEN OVER 1 HOUR				
□ Over 2 hour	rs @ mls/ho	our	□ Over 2 hours @ mls/hour				
□ Over 4 hour	rs @ mls/ho	our	□ Over 4 hours @ mls/hour				
☐ Other:	mls/ho	our	□ Other: mls/hour				
□ <u>OTHER (PL</u>	EASE SPECIFY DRUG,	RATE, FREQUENCY, AND DURA	ATION B	ELOW):			
LABS:				NOTES/INSTRU	CTIONS/COMME	ENTS	
ELECT BELOW	LAB REQUESTED	FREQUENCY					
	NONE	NONE					
	CBC w/ Diff	() PRIOR () POST					
	ВМР	() PRIOR () POST					
	CMP	() PRIOR () POST					
	BUN/CREATININE	() PRIOR () POST					
	Other:	() PRIOR () POST					
FLUSHES:	☐ 10 mL NS Flush Syri	inge PRN 🔲 Heparin 500 uni	ts/5 mL	Flush Syringe PRN	□ DO NOT AE	DMINISTER HEPARIN TO THIS PATIENT	
Physician's S	ignature Be Clear and Legible				_Time	Date	
Cosignature (Time	Date	
*Signature Must	Be Clear and Legible					Duit	



STAT REFERRAL

INTRAVENOUS IMMUNO GLOBULIN ORDER FORM

	ENT INFORMATION		First Name			MI DOI	
	Name:in WT:kg Sex:() Male() Fe						
	ies:						
	iry Insurance Name				Policy ID #:		
	ndary Insurance Name						
	cian Name						
Addre	ess:		Ci	ity/State/Zip			
NPI#	<u> </u>	Tax ID#:_			Fax #:		
Prima	TEMENT OF MEDICAL NECESSITY ary Diagnosis: ICD 10 + Description: SCRIPTION ORDERS: IVIG (DOSES WILL BE ROUNDED TO	NEAREST 10 GM	INCREMENT TO	ELIMINATE WAST	E)	-	
PREF	patient have venous access? YES No. a) ALL MEDIPORTS/IV ACCESS WILL BE ACCESS FERRED BRAND (substitution may apply): PROVIDE CTAGAM (J1568) () GAMUNEX-C (J1561) () 0	SED AND FLU	SHED WITH S	SALINE OR HEF		OCOL	
SELECT	DOSE	ROUTE		RATE	REPEAT	EVERY	DURATION
	MG / KG						
	GRAM / KG						
	GRAM(s) (TOTAL)						
PREM		· 		LABS			
SELECT	MEDICATION BENADRYL	DOSE	ROUTE	SELECT	LAB REQUESTED BMP	WHEN () PRIOR () POST	FREQUENCY
	ACETAMINOPHEN				CMP	() PRIOR () POST	
						. , , , , , , , , , , , , , , , , , , ,	
	SOLUMEDROL				BUN/CREATININE	() PRIOR () POST	
	Other:				Other:	() PRIOR () POST	
	Other:				Other:	() PRIOR () POST	
TITRA	ATION						
Begin in then Max ra	fusion atmg/kg/min for 30 minutes,mg/kg/min, then to max rate of te for pre-existing renal insufficiency or through	then if tole _mg/kg/min	rated increa	se every 30		mg/kg/min, then	mg/kg/min,
NOTE	ES/INSTRUCTIONS/COMMENTS						
ELLIS	HES: 10 mL NS Flush Syringe PRN Hep	arin 500 unite	5 ml Fluch S	vringe DDN	DO NOT ADMINISTER H	EPARIN TO THIS PATIENT	
Phys	sician's Signature	ariii 500 uiiils/	o nie i lusii o	yinige FRN	Time	Date_	
*Sign	ature Must Be Clear and Legible						



STAT REFERRAL

PRE-PRINTED STANDING PHYSICIAN ORDERS

	INFORMATION		FRE-FRINTED STANDING FIT	SICIAN ONDERS	
	INFORMATION				
					MIDOB:
Diagnosis	: (ICD 10 + Descripti	on:			
Physician	Name		Contact Name	Contact F	Phone #
PRESCRI	PTION ORDERS:				
0	Diphenhydra	amine 25mg IV x 1 as	s needed for symptoms of ra	sh/itching	
0	Epi-Pen_Add	alt 0.3mg / 0.3ml IM x	1 dose as needed for anaph	nylaxis / hypersensitivity rea	action
0	Zofran 4 mg	IV Q4H for nausea			
0	Solu-Medrol	125mg IV x 1 only as	s needed for difficulty breath	ning or allergic reaction	
0	Acetaminop	hen 650mg PO x 1 or	nly for increase in temp > 10	1	
0	Other:				
•		any other Patient confusion will be discon	oncerns, the attending physi ntinued.	cian will be contacted by p	hone. If unable to contact
•	NOTE: In c	ase of an emergenc	y, patient will be transported	d to nearest Emergency Ro	oom.
Physicia	an's Signature e Must Be Clear and I	l eaible		Time	Date
-		•			
	ture (If Required) • Must Be Clear and			Time	Date



STAT REFERRAL

<u>PROLIA (DENOSUMAB)</u>	ONDERTORM	
PATIENT INFORMATION		
Last Name: First Name:		MIDOB:
HT:in WT:kg Sex:() Male () Female SSN:	Home#:	Cell#:
AddressCity/State/		
Allergies:		
Primary Insurance Name	Policy ID #:	
Secondary Insurance Name		
Physician Name Contact Name		
Address: City/State/Z		
NPI#:Tax ID#:		
STATEMENT OF MEDICAL NECESSITY		
Primary Diagnosis: (ICD-10 CODE + DESCRIPTION)		
	Date of	Diagnosis:
PROLIA (DENOSUMAB) 60 mg/		
GIVE ONCE EVERY 6 MC	ONTHS X 1 YEAR	
PROLIA (DENOSUMAB) PATIENTS MUST FALL WITHIN ONE OF THE LISTED CATE	EGORIES BELOW	
1) OSTEOPOROSIS – (Standard Documentation Requirements Listed Below	<u>w):</u>	
 CALCIUM MUST BE CHECKED WITHIN THE LAST 30 DAYS OF THE APP ORIGINAL BONE DENSITY / DEXA SCAN SUPPORTING THE DIAGNOSIS H+P OR OFFICE NOTES LISTING THE DIAGNOSIS OF OSTEOPOROSIS APPOINTMENT PRIOR/CURRENT MEDICATIONS MUST BE DOCUMENTED IN PATIENT'S 	S OF OSTEOPOROSIS IN THE PATIENT RECORD DATE	
2) MEN AT HIGH RISK OF FRACTURE RECEIVING ANDROGEN DEPRIVATI	ON THERAPY FOR NONMETAS	TATIC PROSTATE CANCER
3) TREATMENT TO INCREASE BONE MASS IN WOMEN AT HIGH RISK FOR BREAST CANCER	R FRACTURE RECEIVING AROM	IATASE INHIBITOR THERAPY FOR
*OSTEOPENIA IS NOT AN APPROVED DIAGNOSIS FOR PROLIA (DENOSUMAB). FOR ORIGINAL BONE DENSITY RESULT OR DEXA SCAN SUPPORTING THE DIAGNOSIS FRACTURE		
LABS NEEDED: CALCIUM if previous results not provided within last 30 days)		
SPECIAL NOTE: PROLIA (DENOSUMAB) IS CONTRAINDICATED IN PATIENTS WIT	H HYPOCALCEMIA	
Physician's Signature	Time	Date
*Signature Must Be Clear and Legible		
Cosignature (If Required) *Signature Must Be Clear and Legible	Time	Date



RECLAST 5 mg / 100 ml IV ORDER FORM

PATIENT INFO				
				MIDOB:
				Cell#:
Address				
				and and Discount the
				ontact Phone #
STATEMEN	T OF MEDICAL NECESSITY nosis: (ICD-10 CODE + DESCRIPTION	ON)		e of Diagnosis:
Does patien	nt have venous access?			y or Blagnoold.
-		☐ PIV ☐ PICC LINE ☐	OTUED:	
-		CESSED AND FLUSHED WITH SALINE (7000
a) ALL MEDII	PORTS/IV ACCESS WILL BE AC	JESSED AND FLOSHED WITH SALINE C	JR NEPARIN PER NOSPITAL PROT	OCOL
PRESCRIPT	TION ORDERS			
1) <u>C</u>	OSTEOPOROSIS – Standard CALCIUM MUST BE CHECKED ORIGINAL BONE DENSITY / DE	OVER NO LESS THAN 15 MI PIENTS MUST FALL WITHIN ONE I Documentation Requirements Li WITHIN THE LAST 30 DAYS OF THE EXA SCAN SUPPORTING THE DIAGNO	OF THE LISTED CATEGORIES Sted Below): APPOINTMENT OSIS OF OSTEOPOROSIS	S BELOW:
• P	PPOINTMENT			OCUMENTED IN PATIENT'S MEDICAL
2) T	REATMENT AND PREVENTIO	N OF GLUCOCORTICOID-INDUCED O		
3) T	REATMENT OF PAGET'S DIST	EASE OF BONE IN MEN AND WOMEN		
LABS NEED	DED: BUN and CREATININ	IE (if previous results not prov	ided within last 30 days)	
NOTE: REC	LAST (ZOLEDRONIC ACID) IS	CONTRAINDICATED IN PATIENTS W	/ITH CrCl < 35 ml/min	
FLUSHES: [10 mL NS Flush Syringe PRN	Heparin 500 units/5 mL Flush Syring	ge PRN DO NOT ADMINISTER	R HEPARIN TO THIS PATIENT
Physician's *Signature Mu	Signature ust Be Clear and Legible		Time	Date
	e (If Required) ust Be Clear and Legible		Time	Date



RENFLEXIS (INFLIXIMAB-ABDA) ORDER FORM

PATIENT	<u> INFORMATION</u>						
						MIDOB:	
	in WT:kg Sex:() Mal						
	·						
	nsurance Name						
	ry Insurance Name				· ·		
	n Name						
	MENT OF MEDICAL NECESSITY ICD				Fax #:		
SIAILI	MENT OF MEDICAL NECESSITI	- 10 Code plus Desc	приоп				
DEDTIN	IENT MEDICAL HISTORY ALTRIANS		N. D				-
	IENT MEDICAL HISTORY 1) TB test p		·-				
	t diagnosed with Congestive Heart Failure?						
	t previously treated with Remicade? O Yes			-	rface antibody test? O Yes O	No Date:	-
	<u>/ ACCESSES WILL BE FLUSHED WITH SA</u> KIMAB-ABDA WILL BE ADMINISTERED IN				MITH A 1.2 MICDON FILTED		
PRESC	RIPTION ORDERS RENFLEXIS ® (IN	FLIXIMAB-ABDA)	ALL DOSES	WILL BE ROUN	DED TO NEAREST 100 MG V	IAL	
Does pa	tient have venous access?	☐ NO					
If yes, w	hat type: MEDIPORT P	V PICC LINE	□ отн	IER:			
SELECT	DOSING OPTIONS	DOSE	ROUTE		FREQUENCY (POPULA	TE RELOW)	DURATION
OLLLOI	LOADING DOSES (WEIGHT BASED)	MG / KG	IV	0. 2. 6 WEEKS	S, THEN ONCE EVERY	WEEKS	DONATION
	LOADING DOSES (FLAT DOSE)		IV		S, THEN ONCE EVERY	WEEKS	
	, ,	MG				WEEKS	
	MAINTENANCE DOSE	5 MG / KG	IV	ONCE EVERY			
	MAINTENANCE DOSE	10 MG / KG	IV	ONCE EVERY			
	FLAT DOSE	MG	IV	ONCE EVERY	WEEKS		
PREMED ELECT	OS MEDICATION	DOSE	ROUTE	LABS SELECT	LAB REQUESTED	WHEN	FREQUENCY
	BENADRYL				BMP	() PRIOR () POST	
	ACETAMINOPHEN				CMP	() PRIOR () POST	1
	OXYGEN			-	BUN/CREATININE	() PRIOR () POST	
	Other:				CRP:	() PRIOR () POST	
						` ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	
	Other:				ESR:	() PRIOR () POST	
	Other:				Other:	() PRIOR () POST	
NOTES/I	NSTRUCTIONS/COMMENTS						
FLUSHE	S: 10 mL NS Flush Syringe PRN	Heparin 500 units	/5 mL Flush	Syringe PRN	DO NOT ADMINISTER H	IEPARIN TO THIS PATIENT	
Dhyele!	on's Signature				T:	Data	
	an's Signature re Must Be Clear and Legible				Time	Date	
•	-				T*	D-4-	
*Signatu	ature (If Required) re Must Be Clear and Legible				Time	Date	



STAT REFERRAL

BONE MARROW STIMULATING AGENTS

PATIENT INF	FORMATION .						
Last Name: _			First Name:			MIDOB:	
HT:	in WT:	kg Sex:() Male () Female SSN:		Home#:		_Cell#:	
Address			City/State/	Zip			
Allergies:							
Primary Insur	rance Name			Policy IE) #:		
Secondary In	nsurance Name			Policy ID	#:		
Physician Na	ime	(Contact Name		Contact Phone	#	
Address:			City/State/Z	ip			
NPI #:					Fax#:		
<u>STATEM</u>	ENT OF MED	DICAL NECESSITY Primary Diagnosis	: (ICD-10 Code plus D	escription)			
a) <u>N</u> PRESCR	IPTION ORD	ITUTED WITH BIOSIMILAR EQUIVILEN			to (lat	o value)	
		<u> </u>	•	-		,	=
SELECT	Augusau	MEDICATION	DOSE	ROUTE	FREQUENCY	DURATION	<u> </u>
	Aranesp						
	Neulasta						
	Neupoge	n					
	Procrit						
	Other:						
NOTES:							
Physician's *Signature M	s Signature lust Be Clear and L	egible		т	ime	Date	
	re (If Required)_ lust Be Clear and L	.egible		Ti	me	Date	



STAT REFERRAL

TYSABRI (NATALIZUMAB)

				Cinct Manage	_		MI DOD.	
пі							MIDOB: Cell#:	
Addroce								
· —						Policy ID #:		
							ntact Phone #	
NPI #:			Tax ID	#:		Fax#:		
		DICAL NECESSITY						
Primary Diagn	iosis: (ICD-10 Co	de plus Description)						
Does the patie If No, does pa PRESCRI Does patien If yes, what	tient need venou PTION ORD It have venous type:	access? O Yes O No s access? O Yes O No ERS s access? Yes MEDIPORT P	If Yes, hos NO V P	at type? pital will make a	rrangements.	:RIN PER HOSPITAL PROTO		
Drug	PORTS/IV ACC	Dose	AND FLUSI	Route			Durati	on
Tysabr				IV		Frequency very 28 days	12 months	
iysabi	1	300mg		1 V	L	rery 20 days	12 111011	1013
PREMEDS					LABS			
								_
LECT LOW	MED	ICATION	DOSE	ROUTE	SELECT BELOW	LAB REQUESTED	WHEN	FREQUENC
LECT		DICATION	DOSE	NA		JCV ANTIBODY	WHEN PRIOR	
LECT LOW NON		DICATION			BELOW	·		
LECT LOW NON BEN	IE .	DICATION			BELOW	JCV ANTIBODY	PRIOR	
NON BEN ACE	ie Adryl	DICATION			BELOW	JCV ANTIBODY BMP	PRIOR () PRIOR () POST () PRIOR () POST	
NON BEN ACE	ADRYL TAMINOPHEN	DICATION			BELOW	JCV ANTIBODY BMP CMP BUN/CREATININE	PRIOR () PRIOR () POST () PRIOR () POST () PRIOR () POST	FREQUENC' EVERY 6 MONT
NON BEN ACE OXY	ADRYL TAMINOPHEN GEN Pr:	DICATION			BELOW	JCV ANTIBODY BMP CMP BUN/CREATININE CRP:	PRIOR () PRIOR () POST	
NON BEN ACE	ADRYL TAMINOPHEN GEN Pr:	DICATION			BELOW	JCV ANTIBODY BMP CMP BUN/CREATININE	PRIOR () PRIOR () POST () PRIOR () POST () PRIOR () POST	
NON BEN ACE OXY	ADRYL TAMINOPHEN GEN er:	DICATION			BELOW	JCV ANTIBODY BMP CMP BUN/CREATININE CRP:	PRIOR () PRIOR () POST	
NON BEN ACE OXY Othe Othe	ADRYL TAMINOPHEN GEN er:	DICATION			BELOW	JCV ANTIBODY BMP CMP BUN/CREATININE CRP: ESR:	PRIOR () PRIOR () POST () PRIOR () POST	
NON BEN ACE OXY Othe	ADRYL TAMINOPHEN GEN er: er:	DICATION	NA NA	NA NA	X	JCV ANTIBODY BMP CMP BUN/CREATININE CRP: ESR: Other:	PRIOR () PRIOR () POST () PRIOR () POST	



STAT REFERRAL

XOLAIR (OMALIZUMAB)

Activation Last Name:	Last Name:					VOLVIIV (DIVIALIZUIVI	<u>ADJ</u>		
HT:in_WT:kg_Sex:() Male () Female SSN: Home#: Cell#; Address	HT; in WT; kg Sex () Male () Female SSN: Horre#; Call#;			<u>-</u>						
Address	Allergies Policy D #:									
Allergies:	Allergies: Primary Insurance Name Secondary Insurance Name Policy ID #: Secondary Insurance Name Policy ID #: Secondary Insurance Name Contact Name Contact Name Contact Phone # Lass Lass Leet Las RecoursireD Novie NA NA NA BENAPY Comp () PRIOR () POST Contact Phone # Contact Phone # Contact Phone # Lass Lass Lass Lass Leet Las RecoursireD Novie NA NA NA BENAPY Comp () PRIOR () POST Contact Phone # Contact P									
Policy D #:	Primary Insurance Name									
Policy D # Policy D # Policy D # Policy D # Physician Name	Policy D # Poli							D.I' ID #		
Physician Name	Physician Name							•		
Address:	Address:									
PRESCRIPTION ORDERS	Statement of Medical Necessity									
STATEMENT OF MEDICAL NECESSITY Primary Diagnosis: (ICD-10 Code plus Description) Date of Diagnosis: PRESCRIPTION ORDERS Drug	STATEMENT OF MEDICAL NECESSITY Primary Diagnosis: (ICD-10 Code plus Description) PRESCRIPTION ORDERS Drug Dose Route Frequency Duration XOLAIR SQ Everydays 12 months LABS LABS LECT LAB REQUESTED WHEN FREG BELOW NONE NA NA NA BENADRYL BENADRYL BENADRYL SACETAMINOPHEN () PRIOR () POST CMP. ACETAMINOPHEN CONGEN BUNCREATININE () PRIOR () POST CMP. Other: Diener () PRIOR () POST CMP. Other: () PRIOR () POST CMP. DOTHER: () PRIOR () POST CMP. Other: () PRIOR () POST CMP. DOTHER: ()									
Primary Diagnosis: (ICD-10 Code plus Description) Date of Diagnosis: PRESCRIPTION ORDERS Drug Dose Route Frequency Duration XOLAIR SQ Everydays 12 months LABS LACT LAB ACUETA LAB ACUETA LAB ACUETA LABS LACT LAB ACUETA LAB ACUETA LAB ACUETA LAB ACUETA LAB ACUETA LABS LA	Primary Diagnosis: (ICD-10 Code plus Description) Date of Diagnosis: PRESCRIPTION ORDERS Drug	_		OF MEDICAL NECESS	TY	ID#				
Drug Dose Route Frequency Duration	PRESCRIPTION ORDERS Drug				<u></u>					
Drug Dose Route Frequency Duration	Drug Dose Route Frequency Duration									_
SQ Every	SQ Every				T	Route		Frequency	Durati	on
SELECT MEDICATION DOSE ROUTE SELECT BELOW NA NA NA NA NA NA NA N	NONE					SQ			12 mon	iths
BELOW BELOW NA	BELOW BELOW NA		EDS			2005				
BENADRYL BMP	BENADRYL ACETAMINOPHEN OXYGEN Other: Other: Other: Other: Other: Other: Other: Time Date Physician's Signature "Signature Must Be Clear and Legible DXYGEN BMP () PRIOR () POST			MEDICATION	DOSE	ROUTE		LAB REQUESTED	WHEN	FREQUENC
ACETAMINOPHEN CMP	ACETAMINOPHEN CMP		NONE		NA	NA		NONE	NA	NA
ACETAMINOPHEN CMP	ACETAMINOPHEN CMP		BENADR	YL				BMP	() PRIOR () POST	
OXYGEN BUN/CREATININE () PRIOR () POST Other: CRP: () PRIOR () POST Other: ESR: () PRIOR () POST Other: Other: () PRIOR () POST	Date								, , , , , ,	
Other: CRP: () PRIOR () POST Other: ESR: () PRIOR () POST Other: () PRIOR () POST	Other:								. , , , ,	
Other: ESR: () PRIOR () POST Other: () PRIOR () POST	Other: Date *Signature Must Be Clear and Legible		OXTGEN					BUN/CREATININE		
Other: Other: () PRIOR () POST	Other: Other: Other: Other: Other: Other: Other: Date Physician's Signature *Signature Must Be Clear and Legible		Other:					CRP:	() PRIOR () POST	
	NOTES:		Other:					ESR:	() PRIOR () POST	
NOTES:	Physician's Signature		Other:					Other:	() PRIOR () POST	
	*Signature Must Be Clear and Legible	NOTE	:S:					l		
	*Signature Must Be Clear and Legible									
	On the of the USD with the	Physic *Signat	cian's Sig ture Must Be	nature e Clear and Legible				Time	Date	
Physician's SignatureTimeDate *Signature Must Be Clear and Legible	Cosignature (If Required)	Cosia	nature (If	Required)				Time	Date	



STAT REFERRAL

SIMPONI ARIA (GOLIMUMAB)

PATIEN	<u>IT INFORMATION</u>								
		Sex:() Male () Female SSN:							
					-				
Allergies	S:								
_	EMENT OF MEDICAL	Tax ID	#:			Fax#:			
	Diagnosis: (ICD-10 Code plus								
Does the If No, do PRES	Diagnosis: te patient have venous access on patient need venous access occupatient need venous access occupatient have venous access obtained the patient have venous access what type: MEDIF	? O Yes O No If Yes, who if Yes, hoses? OYES O NO If Yes, hoses?	pital w	ll make a	rrangements.				
		ILL BE ACCESSED AND FLUSH							
	Drug	Dose		R	Route	Frequency	1	D	uration
s	SIMPONI ARIA			IV		Every	weeks	12 months	
PREME	-				LABS				
LOW	MEDICATION			DUTE	SELECT BELOW	LAB REQUESTED		WHEN	FREQUENC
	NONE	NA	NA	1		NONE	NA		NA
	BENADRYL					BMP	() PRIOI	R ()POST	
	ACETAMINOPHEN					CMP	() PRIO	R ()POST	
	OXYGEN					BUN/CREATININE	() PRIO	R ()POST	
	Other:					CRP:	() PRIO	R ()POST	
	Other:					ESR:	() PRIO	R ()POST	
	Other:					Other:	() PRIO	R ()POST	
NOTE	S·			<u> </u>	1				
Physic	cian's Signature					_Time_		Date	
·	ure Must Be Clear and Legible nature (If Required)					Time		Date	



STAT REFERRAL

ORENCIA (ABATACEPT)

ORENCIA (LOADING DOSES) IV 0, 2, 4 weeks, then once every 4 weeks ORENCIA 500 mg IV Every 4 weeks ORENCIA 750 mg IV Every 4 weeks ORENCIA 1000 mg IV Every 4 weeks PREMEDS LABS LECT MEDICATION DOSE ROUTE ELOW NONE NA		Cell#:	Home#:	y/State/Zip	SN:	kg Sex:() Male() Female SS		
Aldress City/State/Zip Allergies: Primary Insurance Name Policy ID #: Secondary Insurance Name Policy ID #: Physician Name Contact Name Policy ID #: Physician Name Contact Name Policy ID #: Physician Name Contact Phone # Address: City/State/Zip Fax #: STATEMENT OF MEDICAL NECESSITY Primary Diagnosis: (ICD-10 Code plus Description) Date of Diagnosis: Does the patient have venous access? O Yes O No If Yes, what type? If No, does patient need venous access? O Yes O No If Yes, hospital will make arrangements. PRESCRIPTION ORDERS Does patient have venous access? Yes No If Yes, hospital will make arrangements. PRESCRIPTION ORDERS Does patient have venous access? Pres No If Yes, what type? 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 PROTOCOL ELECT Drug Dose Route Frequency ORENCIA (LOADING DOSES) IV 0, 2, 4 weeks, then once every 4 weeks ORENCIA 500 mg IV Every 4 weeks ORENCIA 750 mg IV Every 4 weeks ORENCIA 1000 mg IV Every 4 weeks PREMEDS LABS LECT LAB REQUESTED WHEN NONE NA				y/State/Zip			in WT:	HT:
Primary Insurance Name					Cir			
Primary Insurance Name			Policy ID #:					
Secondary Insurance Name			Policy ID #:					
Physician Name								
Address:								
STATEMENT OF MEDICAL NECESSITY								
STATEMENT OF MEDICAL NECESSITY Primary Diagnosis: (ICD-10 Code plus Description) Date of Diagnosis: (ICD-10 Code plus Description) Does the patient have venous access? O Yes O No If Yes, what type? If No, does patient need venous access? O Yes O No If Yes, hospital will make arrangements. PRESCRIPTION ORDERS 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 PROTOCOL ELECT Drug Dose Route Frequency ORENCIA (LOADING DOSES) IV 0, 2, 4 weeks, then once every 4 weeks ORENCIA 500 mg IV Every 4 weeks ORENCIA 750 mg IV Every 4 weeks ORENCIA 1000 mg IV Every 4 weeks DRENCIA 1000 mg IV Every 4 weeks ELECT MEDICATION DOSE ROUTE BELOW LAB REQUESTED WHEN BENADRYL BMP () PRIOR () POST CMP () PRIOR () POST CMP	_							
Primary Diagnosis: (ICD-10 Code plus Description) Date of Diagnosis:	-		hax#:		ID#:			
Does the patient have venous access? O Yes ONo If Yes, what type?								
a) ALL MEDIPORTS/IV ACCESS WILL BE ACCESSED AND FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL PROTOCOL Drug				ngements.	nospital will make arra	access? O Yes O No If Yes, It us access? O Yes O No If Yes, It DERS	tient have venous ac patient need venous a RIPTION ORDE	Does the pate of No, does person PRESCR
Dose Route Frequency					_			
ORENCIA (LOADING DOSES) IV 0, 2, 4 weeks, then once every 4 weeks ORENCIA 500 mg IV Every 4 weeks ORENCIA 750 mg IV Every 4 weeks ORENCIA 1000 mg IV Every 4 weeks PREMEDS LECT MEDICATION DOSE ROUTE ELOW NONE NA	Duration						DIPORTS/IV ACCES	
Weeks ORENCIA 500 mg IV Every 4 weeks	12 months	· · · · · · · · · · · · · · · · · · ·			Dose	-	ODENCIA	ELECT
ORENCIA 500 mg IV Every 4 weeks ORENCIA 750 mg IV Every 4 weeks ORENCIA 1000 mg IV Every 4 weeks PREMEDS LABS LECT MEDICATION DOSE ROUTE SELECT LAB REQUESTED WHEN SELECT BELOW NONE NA BENADRYL BMP () PRIOR () POST CMP () PRIOR () POST BUN/CREATININE () PRIOR () POST	12 monus	•		IV		JIA (LUADING DUSES)	UKENCIA	
ORENCIA 750 mg IV Every 4 weeks	12 months			IV	500 mg	ORFNCIA		
ORENCIA 1000 mg IV Every 4 weeks	12 months	•						
LABS								
LECT MEDICATION DOSE ROUTE NONE NA NA NA BENADRYL ACETAMINOPHEN OXYGEN BOSE ROUTE SELECT BELOW NONE NA NONE SHECT LAB REQUESTED WHEN WHEN WHEN CMP () PRIOR () POST BUN/CREATININE () PRIOR () POST	12 months	ery 4 weeks	Eve		1000 mg	URENCIA		DDEMEDS
NONE NA NA BENADRYL BMP () PRIOR () POST ACETAMINOPHEN CMP () PRIOR () POST OXYGEN BUN/CREATININE () PRIOR () POST	FREQUENCY	WHEN	LAB REQUESTED	SELECT	ROUTE	DICATION DOSE	MEDIC	LECT
BENADRYL BMP () PRIOR () POST CMP () PRIOR () POST OXYGEN BUN/CREATININE () PRIOR () POST	NA NA	NA	NONE		NA.	NA NA	ME	
ACETAMINOPHEN OXYGEN CMP () PRIOR () POST BUN/CREATININE () PRIOR () POST	- NA				140	IVA.		
OXYGEN BUN/CREATININE () PRIOR () POST		` ' ' ' ' '						
							CETAMINOPHEN	AC
OIL CORPORT CORPORT		() PRIOR () POST	BUN/CREATININE				CYGEN	ОХ
Other: CRP: () PRIOR () POST		() PRIOR () POST	CRP:				her:	Otl
Other: ESR: () PRIOR () POST		() PRIOR () POST	ESR:				her:	Oti
Other: Other: () PRIOR () POST		() PRIOR () POST	Other:				her:	Oti
NOTES:								NOTES:_
Physician's Signature Time Date *Signature Must Be Clear and Legible		Date	Time			Legible		
Cosignature (If Required) Time Date *Signature Must Be Clear and Legible		_	Time				re (If Required)	Cosignatu



STAT REFERRAL

VENOFER (IRON SUCROSE)

			<u> 7</u>	ENUFER (IRU	N SUCKUS	<u>=)</u>		
	NT INFORMATION							
							MIDOB:_	
							Cell#:	
					State/Zip			_
	es:							
							ct Phone #	
	TEMENT OF MEDIC					Fax#:		
	TEMENT OF MEDIC y Diagnosis: (ICD-10 Code		<u>.T</u>					
	f Diagnosis:							_
	he patient have venous acc			ype?				
If No, d	loes patient need venous a	ccess? OYes O N	o If Yes, hospit	tal will make arrang	ements.			
DDE	SCDIDTION ODDER	oe .						
PKE	SCRIPTION ORDER	_		Donato		F	D	4!
	Drug	Do	ose	Route		Frequency	Dura	tion
	VENOFER			IV	Evei	ydays		
						<u>,</u> ,		
PREME Lect	EDS MEDICAT	ION	DOSE	ROUTE	SELECT	LAB REQUESTED	WHEN	FREQUENCY
LOW	MEDIOAT	Ю	DOOL	KOOIL	BELOW	LAB REQUESTED	WILL	TALQUENCT
	NONE		NA	NA		NONE	NA	NA
	BENADRYL		50mg	IV		ВМР	() PRIOR () POST	
	ACETAMINOPHEN					CMP	() PRIOR () POST	
	OXYGEN					BUN/CREATININE	() PRIOR () POST	
	EPINEPHRINE		0.3mg / 0.3ml	IM		CRP:	() PRIOR () POST	
	SOLU-MEDROL		125mg	IV		ESR:	() PRIOR () POST	
	Other:					Other:	() PRIOR () POST	
			1			1		ı
NOTE	S:							
Physi	cian's Signature					Time	Date	
*Signa	ture Must Be Clear and Leg	ible						
Cosia	nature (If Required)					Time	Date	
*Signa	ture Must Be Clear and Leg	ible						



STAT REFERRAL

OCREVUS (OCRELIZUMAB)

PATIEN	T IN	FORMATION .								
									MIDOB:	
									Cell#:	
Address					Ci	ity/State/Zip _				
Allergies	:									
Primary	Insu	rance Name						Policy ID #:		
	-							· · · · · · · · · · · · · · · · · · ·		
Physicia	n Na	ame			Contact Name	e		Conta	ct Phone #	
NPI#:		ENT OF MEDIO	AL MEGEORITY	Tax	(ID#:			Fax#:		
		nosis: (ICD-10 Code pl								
Does the If No, do PRES Does p	e pai es p CR atie	nosis:	ss? O Yes ONo less? O Yes O No S cess? Yes O No P P P	If Yes, I	nospital will make arra O PICC LINE	angements.	! <u> </u>	PER HOSPITAL PROTOC		
	-		Descri		Door	Davida		Г		Dation
ELEC1		OCDEVILIS	Drug	D)	Dose	Route)		quency	Duration
			(OCRELIZUMA DING DOSES)	Б)	300mg	IV			weeks, then 600mg very 6 months	12 month
		OCREVUS	(OCRELIZUMA NENCE DOSES	•	600 mg	IV			6 months	12 month
PREMEI	DS	· · · · · · · · · · · · · · · · · · ·		,		LABS				
LECT		MEDICAT	ION	DOSE	ROUTE	SELECT BELOW		LAB REQUESTED	WHEN	FREQUENCY
	NO	NE		NA	NA		NO	NE	NA	NA
	BE	NADRYL					BM	P	() PRIOR () POST	
	AC	ETAMINOPHEN					CM	P	() PRIOR () POST	
		YGEN					BU	N/CREATININE	() PRIOR () POST	
	Oth	ner:					CR	P:	() PRIOR () POST	
	Oth	ner:					ES	R:	()PRIOR ()POST	
	Oth	ner:					Oth	ner:	() PRIOR () POST	
NOTES	٥.						<u> </u>			
	o									
FLUSHE	S:	10 mL NS Flush	Syringe PRN H	eparin 500	units/5 mL Flush Sy	ringe PRN		DO NOT ADMINISTER HE	PARIN TO THIS PATIENT	
Physic *Signatu	ian' re N	s Signature Just Be Clear and Legib	le					Time	Date	
		re (If Required) fust Be Clear and Legib	le					Time	Date	
0		3								



|--|

REMICADE (INFLIXIMAB) ORDER FORM

HT:							
						MIDOB:	
Address	in WT:kg Sex:() Male						
nuui 633				City/State/Zip			
-							
Primary Ins	surance Name				Policy ID #:		
Secondary	Insurance Name				Policy ID #:		
	Name					tact Phone #	
					Fax #:		
<u>STATEM</u>	ENT OF MEDICAL NECESSITY ICD	-10 Code plus Desc	ription				
PERTINE	ENT MEDICAL HISTORY 1) TB test p	erformed? O Yes O	No Results,				_
2) Patient of	diagnosed with Congestive Heart Failure?	O Yes O No 3) Liv	er function tes	st normal? O Yes	O No		
4) Patient	previously treated with Remicade? O Yes	O No Date:	5) I	Hep-B antigen su	face antibody test? O Yes O	No Date:	_
	ACCESSES WILL BE FLUSHED WITH SAI						
	MAB WILL BE ADMINISTERED IN NS 0.9 E SUBSTITUTED WITH BIOSIMILAR EQU						
PRESCR	IPTION ORDERS: REMICADE® (INF	-LIXIMAB) ALL DO	SES WILL BE	E ROUNDED TO	NEAREST 100 MG VIAL		
Does patie	ent have venous access? YES	NO					
Does pation	_	V PICC LINE	□ OTH	IER:			
If yes, wha	at type: MEDIPORT PI	V PICC LINE		IER:			DURATION
•	at type: MEDIPORT PI	V PICC LINE DOSE	ROUTE		FREQUENCY (POPULA	TE BELOW)	DURATION
If yes, wha	DOSING OPTIONS LOADING DOSES (WEIGHT BASED)	PICC LINE DOSE MG / KG	ROUTE IV	0, 2, 6 WEEKS	FREQUENCY (POPULA:	TE BELOW) WEEKS	DURATION
If yes, wha	DOSING OPTIONS LOADING DOSES (WEIGHT BASED) LOADING DOSES (FLAT DOSE)	DOSE MG / KG	ROUTE IV	0, 2, 6 WEEKS	FREQUENCY (POPULA F, THEN ONCE EVERY F, THEN ONCE EVERY	TE BELOW)	DURATION
If yes, wha	DOSING OPTIONS LOADING DOSES (WEIGHT BASED) LOADING DOSES (FLAT DOSE) MAINTENANCE DOSE	DOSE MG / KG MG 5 MG / KG	ROUTE IV IV	0, 2, 6 WEEKS 0, 2, 6 WEEKS ONCE EVERY	FREQUENCY (POPULA F, THEN ONCE EVERY F, THEN ONCE EVERY WEEKS	TE BELOW) WEEKS	DURATION
If yes, wha	DOSING OPTIONS LOADING DOSES (WEIGHT BASED) LOADING DOSES (FLAT DOSE) MAINTENANCE DOSE MAINTENANCE DOSE	DOSE MG / KG MG 5 MG / KG 10 MG / KG	ROUTE IV IV IV	0, 2, 6 WEEKS 0, 2, 6 WEEKS ONCE EVERY	FREQUENCY (POPULA F, THEN ONCE EVERY F, THEN ONCE EVERY WEEKS WEEKS	TE BELOW) WEEKS	DURATION
If yes, what	DOSING OPTIONS LOADING DOSES (WEIGHT BASED) LOADING DOSES (FLAT DOSE) MAINTENANCE DOSE MAINTENANCE DOSE FLAT DOSE	DOSE MG / KG MG 5 MG / KG	ROUTE IV IV	0, 2, 6 WEEKS 0, 2, 6 WEEKS ONCE EVERY	FREQUENCY (POPULA F, THEN ONCE EVERY F, THEN ONCE EVERY WEEKS WEEKS	TE BELOW) WEEKS	DURATION
If yes, who	DOSING OPTIONS LOADING DOSES (WEIGHT BASED) LOADING DOSES (FLAT DOSE) MAINTENANCE DOSE MAINTENANCE DOSE FLAT DOSE	DOSE MG / KG MG 5 MG / KG 10 MG / KG MG	ROUTE IV IV IV IV IV	0, 2, 6 WEEKS 0, 2, 6 WEEKS ONCE EVERY ONCE EVERY LABS	FREQUENCY (POPULA F, THEN ONCE EVERY F, THEN ONCE EVERY WEEKS WEEKS	TE BELOW) WEEKS WEEKS	
PREMEDS	DOSING OPTIONS LOADING DOSES (WEIGHT BASED) LOADING DOSES (FLAT DOSE) MAINTENANCE DOSE MAINTENANCE DOSE FLAT DOSE	DOSE MG / KG MG 5 MG / KG 10 MG / KG	ROUTE IV IV IV	0, 2, 6 WEEKS 0, 2, 6 WEEKS ONCE EVERY ONCE EVERY	FREQUENCY (POPULA F, THEN ONCE EVERY F, THEN ONCE EVERY WEEKS WEEKS	TE BELOW) WEEKS WEEKS	DURATION
PREMEDS	DOSING OPTIONS LOADING DOSES (WEIGHT BASED) LOADING DOSES (FLAT DOSE) MAINTENANCE DOSE MAINTENANCE DOSE FLAT DOSE MEDICATION	DOSE MG / KG MG 5 MG / KG 10 MG / KG MG	ROUTE IV IV IV IV IV	0, 2, 6 WEEKS 0, 2, 6 WEEKS ONCE EVERY ONCE EVERY LABS	FREQUENCY (POPULA) THEN ONCE EVERY WEEKS WEEKS WEEKS LAB REQUESTED	WEEKS WEEKS WEEKS WHEN () PRIOR () POST	
PREMEDS LECT B A	DOSING OPTIONS LOADING DOSES (WEIGHT BASED) LOADING DOSES (FLAT DOSE) MAINTENANCE DOSE MAINTENANCE DOSE FLAT DOSE MEDICATION SENADRYL ACETAMINOPHEN	DOSE MG / KG MG 5 MG / KG 10 MG / KG MG	ROUTE IV IV IV IV IV	0, 2, 6 WEEKS 0, 2, 6 WEEKS ONCE EVERY ONCE EVERY LABS	FREQUENCY (POPULA) THEN ONCE EVERY WEEKS WEEKS WEEKS LAB REQUESTED BMP CMP	WEEKS WEEKS WHEN () PRIOR () POST	
PREMEDS LECT B	DOSING OPTIONS LOADING DOSES (WEIGHT BASED) LOADING DOSES (FLAT DOSE) MAINTENANCE DOSE MAINTENANCE DOSE FLAT DOSE MEDICATION BENADRYL ACETAMINOPHEN DXYGEN	DOSE MG / KG MG 5 MG / KG 10 MG / KG MG	ROUTE IV IV IV IV IV	0, 2, 6 WEEKS 0, 2, 6 WEEKS ONCE EVERY ONCE EVERY LABS	FREQUENCY (POPULA' F, THEN ONCE EVERY F, THEN ONCE EVERY WEEKS WEEKS WEEKS WEEKS LAB REQUESTED BMP CMP BUN/CREATININE	WHEN () PRIOR () POST () PRIOR () POST	
PREMEDS LECT A	DOSING OPTIONS LOADING DOSES (WEIGHT BASED) LOADING DOSES (FLAT DOSE) MAINTENANCE DOSE MAINTENANCE DOSE FLAT DOSE MEDICATION SENADRYL ACETAMINOPHEN	DOSE MG / KG MG 5 MG / KG 10 MG / KG MG	ROUTE IV IV IV IV IV	0, 2, 6 WEEKS 0, 2, 6 WEEKS ONCE EVERY ONCE EVERY LABS	FREQUENCY (POPULA) THEN ONCE EVERY WEEKS WEEKS WEEKS LAB REQUESTED BMP CMP	WEEKS WEEKS WHEN () PRIOR () POST	
PREMEDS LECT B	DOSING OPTIONS LOADING DOSES (WEIGHT BASED) LOADING DOSES (FLAT DOSE) MAINTENANCE DOSE MAINTENANCE DOSE FLAT DOSE MEDICATION BENADRYL ACETAMINOPHEN DXYGEN	DOSE MG / KG MG 5 MG / KG 10 MG / KG MG	ROUTE IV IV IV IV IV	0, 2, 6 WEEKS 0, 2, 6 WEEKS ONCE EVERY ONCE EVERY LABS	FREQUENCY (POPULA' F, THEN ONCE EVERY F, THEN ONCE EVERY WEEKS WEEKS WEEKS WEEKS LAB REQUESTED BMP CMP BUN/CREATININE	WHEN () PRIOR () POST () PRIOR () POST	
PREMEDS LECT B A C C C	DOSING OPTIONS LOADING DOSES (WEIGHT BASED) LOADING DOSES (WEIGHT BASED) LOADING DOSES (FLAT DOSE) MAINTENANCE DOSE MAINTENANCE DOSE FLAT DOSE MEDICATION BENADRYL CCETAMINOPHEN DXYGEN Other:	DOSE MG / KG MG 5 MG / KG 10 MG / KG MG	ROUTE IV IV IV IV IV	0, 2, 6 WEEKS 0, 2, 6 WEEKS ONCE EVERY ONCE EVERY LABS	FREQUENCY (POPULA) THEN ONCE EVERY WEEKS WEEKS WEEKS LAB REQUESTED BMP CMP BUN/CREATININE CRP:	WEEKS WEEKS WHEN () PRIOR () POST	



STAT REFERRAL

INJECTAFER (FERUMOXYTOL)

			IIN	IJECTAFER (I	ERUNUXTI	<u>OL)</u>		
	NT INFORMATION							
							MIDOB:_	
							Cell#:	
					/State/Zip			_
	es:							_
							1 DI #	
							ct Phone #	
-	TEMENT OF MEDIC					rax#		
	y Diagnosis: (ICD-10 Code i		<u> </u>					
	f Diagnosis:							_
	he patient have venous acc			ype?				
If No, c	does patient need venous a	ccess? Oyes ON	lo If Yes, nospit	al will make arran	gements.			
PRE	SCRIPTION ORDER	RS						
	Drug		ose	Route		Frequency	Dura	tion
	Diag) MG	Route		Trequency	Daia	
I	NJECTAFER	730) IIIO	IV		Every 7 days	X 2 do	oses
PREMI LECT LOW	EDS MEDICAT	TON	DOSE	ROUTE	SELECT BELOW	LAB REQUESTED	WHEN	FREQUENCY
	NONE		NA	NA		NONE	NA	NA
	BENADRYL		50mg	IV		BMP	() PRIOR () POST	
	ACETAMINOPHEN					CMP	() PRIOR () POST	
	OXYGEN					BUN/CREATININE	() PRIOR () POST	
	EPINEPHRINE		0.3mg / 0.3ml	IM		CRP:	() PRIOR () POST	
	SOLU-MEDROL		125mg	IV		ESR:	() PRIOR () POST	
	Other:					Other:	() PRIOR () POST	
	- Canoni						()	
NOTE	-s·							
Phvsi	ician's Signature					Time_	Date	
*Signa	ture Must Be Clear and Legi	ible						
Coein	nature (If Required)					Time	Date	
*Signa	ture Must Be Clear and Legi	ible				111116	Date	
J.y.,u								