CONNALLY MEMORIAL MEDICAL CENTER

CONNALLY MEMORIAL INFUSION CENTER
Phone: 830-477-0424
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, **877-249-1191**, also on the bottom of the "**IV Infusion Order Form**"

4. Call Case Management at **830-477-0424** 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***

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

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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**

CONNALLY MEMORIAL MEDICAL CENTER

☐ **STAT REFERRAL**

CONNALLY MEMORIAL INFUSION CENTER
Phone: 830-477-0424
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BLOOD PRODUCT TRANSFUSION ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____DOB:_____

HT: _____in WT: _____kg Sex :( ) Male ( ) Female SSN:_____Home#:_____Cell#:_____

Address_____ City/State/Zip _____

Allergies:_____

Primary Insurance Name _____ Policy ID #: _____

Secondary Insurance Name_____ Policy ID #:_____

Physician Name_____ Contact Name _____ Contact Phone # _____

Address: _____City/State/Zip_____

NPI #:_____ Tax ID#:_____Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD 10 CODE + DESCRIPTION) _____

Secondary Diagnosis: (ICD 10 CODE + DESCRIPTION) _____

PERTINENT MEDICAL HISTORY

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

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

NOTES:_____

A) ALL MEDIPORTS / IV ACCESS WILL BE ACCESSED AND FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL PROTOCOL PRN
B) 250 cc BAG OF 0.9% NS MAY BE HUNG WITH EACH BLOOD PRODUCT TRANSFUSION
C) TUBING WILL BE FLUSHED WITH 0.9% NS UNTIL TUBING IS PINK TINGED OR CLEAR
D) H+H MUST BE COMPLETED WITHIN 72 HOURS PRIOR TO INITIATION OF ALL BLOOD PRODUCT TRANSFUSIONS

TYPE, CROSSMATCH, AND TRANSFUSE:

SELECT	# of UNITS	PRODUCT
		FRESH FROZEN PLASMA
		LEUKO REDUCED PRBCs
		LEUKO REDUCED IRRADITED PRBCs
		LEUKO REDUCED PLATELETS
		LEUKO REDUCED IRRADIATED PLATELETS
		Other:

LABS

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

PREMEDS

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY
	NONE	**NA**	**NA**	**NA**
	BENADRYL			
	ACETAMINOPHEN			
	OXYGEN			
	LASIX	**20mg**	**IV**	
	Other:			

NOTES/INSTRUCTIONS/COMMENTS

_____
_____
_____
_____
_____
_____

DIETARY RESTRICTIONS (If none, please indicate): _____

FLUSHES: ☐ **10 mL NS Flush Syringe PRN** ☐ **Heparin 500 units/5 mL Flush Syringe PRN** ☐ **DO NOT ADMINISTER HEPARIN TO THIS PATIENT**

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 to the Outpatient Infusion Center at 1 (877) 249-1191.
PLEASE include copies of: H+P, OFFICE NOTES, LABS, ACTIVE MEDICATION PROFILE, and CURRENT INSURANCE INFORMATION in order for your referral to be processed.

CONNALLY MEMORIAL MEDICAL CENTER

☐ **STAT REFERRAL**

CONNALLY MEMORIAL
INFUSION CENTER
Phone: 830-477-0424
Fax: 1-877-249-1191

ENTYVIO (VEDOLIZUMAB) ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____DOB:_____

HT: _____in WT: _____kg Sex :( ) Male ( ) Female SSN:_____Home#:_____Cell#:_____

Address_____ City/State/Zip _____

Allergies:_____

Primary Insurance Name _____ Policy ID #: _____

Secondary Insurance Name_____ Policy ID #:_____

Physician Name_____ Contact Name _____ Contact Phone # _____

Address: _____City/State/Zip_____

NPI #:_____ Tax ID#:_____Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: ICD-10 Code plus Description:_____

PERTINENT MEDICAL HISTORY **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? ○ Yes ○ No Date: _____5) Hep-B antigen surface antibody test? ○ Yes ○ No Date: _____

a) ALL MEDIPORTS / IV ACCESSES WILL BE FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL PROTOCOL
b) ENTYVIO (VEDOLIZUMAB) WILL BE ADMINISTERED IN NS 0.9% 250 ML OVER NO LESS THAN 30 MINUTES WITH A 1.2 MICRON FILTER
C) ALL LINES WILL BE FLUSHED WITH 30 ML OF 0.9% NS UPON COMPLETION OF INFUSION

PRESCRIPTION ORDERS: ENTYVIO (VEDOLIZUMAB)

Does patient have venous access? ☐ **YES** ☐ **NO**

If yes, what type: ☐ **MEDIPORT** ☐ **PIV** ☐ **PICC LINE** ☐ **OTHER:**_____

SELECT	DOSING OPTIONS	DOSE	ROUTE	FREQUENCY (POPULATE BELOW)	DURATION
	LOADING DOSES	**300 MG**	**IV**	**0, 2, 6 WEEKS, THEN ONCE EVERY 8 WEEKS**	
	MAINTENANCE DOSE	**300 MG**	**IV**	**ONCE EVERY 8 WEEKS**	

PREMEDS

SELECT	MEDICATION	DOSE	ROUTE
	NONE	**NA**	**NA**
	BENADRYL		
	ACETAMINOPHEN		
	OXYGEN		
	Other:		
	Other:		
	Other:		

LABS

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

NOTES/INSTRUCTIONS/COMMENTS

_____

_____

FLUSHES: ☐ **10 mL NS Flush Syringe PRN** ☐ **Heparin 500 units/5 mL Flush Syringe PRN** ☐ **DO NOT ADMINISTER HEPARIN TO THIS PATIENT**

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 to the Outpatient Infusion Center at 1 (877) 249-1191.
PLEASE include copies of: H+P, OFFICE NOTES, LABS, ACTIVE MEDICATION PROFILE, and CURRENT INSURANCE INFORMATION in order for your referral to be processed.

CONNALLY MEMORIAL MEDICAL CENTER

☐ **STAT REFERRAL**

CONNALLY MEMORIAL
INFUSION CENTER
Phone: 830-477-0424
Fax: 1-877-249-1191

GENERAL IV ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____DOB:_____

HT: _____in WT: _____kg Sex :( ) Male ( ) Female SSN:_____Home#:_____Cell#:_____

Address_____ City/State/Zip _____

Allergies:_____

Primary Insurance Name _____ Policy ID #: _____

Secondary Insurance Name_____ Policy ID #:_____

Physician Name_____ Contact Name _____ Contact Phone # _____

Address: _____City/State/Zip_____

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 PROTOCOL PRN
b) CONSULT HOSPITAL PHARMACY TO MONITOR AND ADJUST THERAPY FOR PATIENTS RECEIVING VANCOMYCIN OR GENTAMYCIN

NOTE: For patients with central venous access, please select: ☐ **D/C AFTER LAST DOSE** ☐ **PERFORM DAILY/WEEKLY IV SITE CARE PRN UNTIL DISCHARGED**

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

LABS

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

NOTES/INSTRUCTIONS/OTHER

- **Perform daily/weekly IV site care PRN until discharged**
- **Administer Cath-Flo Activase 2mg IVP PRN if line becomes sluggish or occluded**

FLUSHES: ☐ **10 mL NS Flush Syringe PRN** ☐ **Heparin 500 units/5 mL Flush Syringe PRN** ☐ **DO NOT ADMINISTER HEPARIN TO THIS PATIENT**

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 to the Outpatient Infusion Center at 1 (877) 249-1191.
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☐ **STAT REFERRAL**

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Fax: 1-877-249-1191

HYDRATION ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____DOB:_____

HT: _____in WT: _____kg Sex :( ) Male ( ) Female SSN:_____Home#:_____Cell#:_____

Address_____ City/State/Zip _____

Allergies:_____

Primary Insurance Name _____ Policy ID #: _____

Secondary Insurance Name_____ Policy ID #:_____

Physician Name_____ Contact Name _____ Contact Phone # _____

Address: _____City/State/Zip_____

NPI #:_____ Tax ID#:_____Fax #: _____

STATEMENT OF MEDICAL NECESSITY

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

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

☐ **DO NOT ADMINISTER HEPARIN TO THIS PATIENT**

PRESCRIPTION ORDERS FOR HYDRATION

Select the fluid requested AND the corresponding rate below

1.) ☐ NORMAL SALINE	2.) ☐ LACTATED 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 - GIVEN OVER 1 HOUR**	☐ **BOLUS - GIVEN OVER 1 HOUR**
☐ **Over 2 hours @ mls/hour**	☐ **Over 2 hours @ mls/hour**
☐ **Over 4 hours @ mls/hour**	☐ **Over 4 hours @ mls/hour**
☐ **Other: mls/hour**	☐ **Other: mls/hour**

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

LABS:

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

NOTES/INSTRUCTIONS/COMMENTS

_____

_____

_____

_____

_____

FLUSHES: ☐ **10 mL NS Flush Syringe PRN** ☐ **Heparin 500 units/5 mL Flush Syringe PRN** ☐ **DO NOT ADMINISTER HEPARIN TO THIS PATIENT**

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 to the Outpatient Infusion Center at 1 (877) 249-1191.
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☐ **STAT REFERRAL**

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INTRAVENOUS IMMUNO GLOBULIN ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____DOB:_____

HT: _____in WT: _____kg Sex :( ) Male ( ) Female SSN:_____Home#:_____Cell#:_____

Address_____ City/State/Zip _____

Allergies:_____

Primary Insurance Name _____ Policy ID #: _____

Secondary Insurance Name_____ Policy ID #:_____

Physician Name_____ Contact Name _____ Contact Phone # _____

Address: _____City/State/Zip_____

NPI #:_____ Tax ID#:_____Fax #: _____

STATEMENT OF MEDICAL NECESSITY

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

PRESCRIPTION ORDERS: IVIG (DOSES WILL BE ROUNDED TO NEAREST 10 GM INCREMENT TO ELIMINATE WASTE)

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

PREFERRED BRAND (substitution may apply): PROVIDER MUST SELECT BRAND BELOW:

( ) OCTAGAM (J1568) ( ) GAMUNEX-C (J1561) ( ) GAMMAGARD (J1569) ( ) PRIVIGEN (J1459) ( ) Other:_____

SELECT	DOSE	ROUTE	RATE	REPEAT EVERY	DURATION
	MG / KG				
	GRAM / KG				
	GRAM(s) (TOTAL)				

PREMEDS

SELECT	MEDICATION	DOSE	ROUTE
	BENADRYL		
	ACETAMINOPHEN		
	SOLUMEDROL		
	Other:		
	Other:		

LABS

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

TITRATION

☐ SEE ATTACHED PROTOCOL (Check if preferred protocol is established and submit along with order form)

Begin infusion at _____mg/kg/min for 30 minutes, then if tolerated increase every 30 minutes as follows:_____mg/kg/min, then _____mg/kg/min, then _____mg/kg/min, then to max rate of _____mg/kg/min.

• Max rate for pre-existing renal insufficiency or thrombotic risk is 3.3 mg/kg/min

NOTES/INSTRUCTIONS/COMMENTS

FLUSHES: ☐ **10 mL NS Flush Syringe PRN** ☐ **Heparin 500 units/5 mL Flush Syringe PRN** ☐ **DO NOT ADMINISTER HEPARIN TO THIS PATIENT**

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 to the Outpatient Infusion Center at 1 (877) 249-1191.
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☐ **STAT REFERRAL**

PRE-PRINTED STANDING PHYSICIAN ORDERS

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____DOB:_____

HT: _____in WT: _____kg Allergies:_____

Diagnosis: (ICD 10 + Description: _____

Physician Name_____ Contact Name _____ Contact Phone # _____

PRESCRIPTION ORDERS:

- **Diphenhydramine 25mg IV x 1 as needed for symptoms of rash/itching**
- **Epi-Pen_Adult 0.3mg / 0.3ml IM x 1 dose as needed for anaphylaxis / hypersensitivity reaction**
- **Zofran 4 mg IV Q4H for nausea**
- **Solu-Medrol 125mg IV x 1 only as needed for difficulty breathing or allergic reaction**
- **Acetaminophen 650mg PO x 1 only for increase in temp > 101**
- **Other**: _____

_____

_____

- **NOTE:** For any other Patient concerns, the attending physician will be contacted by phone. If unable to contact Physician, infusion will be discontinued.
- **NOTE:** In case of an emergency, patient will be transported to nearest Emergency Room.

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 to the Outpatient Infusion Center at 1 (877) 249-1191.
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☐ **STAT REFERRAL**

PROLIA (DENOSUMAB) ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____DOB:_____

HT: _____in WT: _____kg Sex :( ) Male ( ) Female SSN:_____Home#:_____Cell#:_____

Address_____ City/State/Zip _____

Allergies:_____

Primary Insurance Name _____ Policy ID #: _____

Secondary Insurance Name_____ Policy ID #:_____

Physician Name_____ Contact Name _____ Contact Phone # _____

Address: _____City/State/Zip_____

NPI #:_____ Tax ID#:_____Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD-10 CODE + DESCRIPTION)

_____ Date of Diagnosis: _____

PRESCRIPTION ORDERS

PROLIA (DENOSUMAB) 60 mg/ml, SUBCUTANEOUS
GIVE ONCE EVERY 6 MONTHS X 1 YEAR

PROLIA (DENOSUMAB) PATIENTS MUST FALL WITHIN ONE OF THE LISTED CATEGORIES BELOW

1) **OSTEOPOROSIS – (Standard Documentation Requirements Listed Below):**

- **CALCIUM MUST BE CHECKED WITHIN THE LAST 30 DAYS OF THE APPOINTMENT**
- **ORIGINAL BONE DENSITY / DEXA SCAN SUPPORTING THE DIAGNOSIS OF OSTEOPOROSIS**
- **H+P OR OFFICE NOTES LISTING THE DIAGNOSIS OF OSTEOPOROSIS IN THE PATIENT RECORD DATED WITHIN 1 YEAR PRIOR TO APPOINTMENT**
- **PRIOR/CURRENT MEDICATIONS MUST BE DOCUMENTED IN PATIENT'S MEDICAL RECORD (Examples: Oral calcium, Vitamin D)**

2) **MEN AT HIGH RISK OF FRACTURE RECEIVING ANDROGEN DEPRIVATION THERAPY FOR NONMETASTATIC PROSTATE CANCER**

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

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

LABS NEEDED: CALCIUM if previous results not provided within last 30 days)

SPECIAL NOTE: PROLIA (DENOSUMAB) IS CONTRAINDICATED IN PATIENTS WITH HYPOCALCEMIA

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**

RECLAST 5 mg / 100 ml IV ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____DOB:_____

HT: _____in WT: _____kg Sex :( ) Male ( ) Female SSN:_____Home#:_____Cell#:_____

Address_____ City/State/Zip _____

Allergies:_____

Primary Insurance Name _____ Policy ID #: _____

Secondary Insurance Name_____ Policy ID #:_____

Physician Name_____ Contact Name _____ Contact Phone # _____

Address: _____City/State/Zip_____

NPI #:_____ Tax ID#:_____Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD-10 CODE + DESCRIPTION)

_____ Date of Diagnosis: _____

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

PRESCRIPTION ORDERS

ADMINISTER RECLAST (ZOLEDRONIC ACID) 5 mg/100ml, IVPB
OVER NO LESS THAN 15 MINUTES ONE TIME A YEAR

RECLAST (ZOLEDRONIC ACID) RECIPIENTS MUST FALL WITHIN ONE OF THE LISTED CATEGORIES BELOW:

1) **OSTEOPOROSIS – Standard Documentation Requirements Listed Below):**

- **CALCIUM MUST BE CHECKED WITHIN THE LAST 30 DAYS OF THE APPOINTMENT**
- **ORIGINAL BONE DENSITY / DEXA SCAN SUPPORTING THE DIAGNOSIS OF OSTEOPOROSIS**
- **H+P OR OFFICE NOTES LISTING THE DIAGNOSIS OF OSTEOPOROSIS IN THE PATIENT RECORD DATED WITHIN 1 YEAR PRIOR TO APPOINTMENT**
- **PRIOR/CURRENT MEDICATIONS USED TO TREAT THE DIAGNOSIS OF OSTEOPOROSIS MUST BE DOCUMENTED IN PATIENT'S MEDICAL RECORD. Examples: Oral calcium, Vitamin D**

2) **TREATMENT AND PREVENTION OF GLUCOCORTICOID-INDUCED OSTEOPOROSIS**

3) **TREATMENT OF PAGET'S DISEASE OF BONE IN MEN AND WOMEN**

LABS NEEDED: BUN and CREATININE (if previous results not provided within last 30 days)

NOTE: RECLAST (ZOLEDRONIC ACID) IS CONTRAINDICATED IN PATIENTS WITH CrCl < 35 ml/min

FLUSHES: ☐ **10 mL NS Flush Syringe PRN** ☐ **Heparin 500 units/5 mL Flush Syringe PRN** ☐ **DO NOT ADMINISTER HEPARIN TO THIS PATIENT**

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 to the Outpatient Infusion Center at 1 (877) 249-1191.
PLEASE include copies of: H+P, OFFICE NOTES, LABS, ACTIVE MEDICATION PROFILE, and CURRENT INSURANCE INFORMATION in order for your referral to be processed.

CONNALLY MEMORIAL MEDICAL CENTER

☐ **STAT REFERRAL**

CONNALLY MEMORIAL
INFUSION CENTER
Phone: 830-477-0424
Fax: 1-877-249-1191

RENFLEXIS (INFLIXIMAB-ABDA) ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____DOB:_____

HT: _____in WT: _____kg Sex :( ) Male ( ) Female SSN:_____Home#:_____Cell#:_____

Address_____ City/State/Zip _____

Allergies:_____

Primary Insurance Name _____ Policy ID #: _____

Secondary Insurance Name_____ Policy ID #:_____

Physician Name_____ Contact Name _____ Contact Phone # _____

Address: _____City/State/Zip_____

NPI #:_____ Tax ID#:_____Fax #: _____

STATEMENT OF MEDICAL NECESSITY ICD-10 Code plus Description

_____

PERTINENT MEDICAL HISTORY **1)** TB test performed? ○ Yes ○ No Results,_____

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

4) Patient previously treated with Remicade? ○ Yes ○ No Date: _____5) Hep-B antigen surface antibody test? ○ Yes ○ No Date: _____

a) ALL IV ACCESSES WILL BE FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL PROTOCOL
b) INFLIXIMAB-ABDA WILL BE ADMINISTERED IN NS 0.9% 250 ML OVER NO LESS THAN 2 HOURS WITH A 1.2 MICRON FILTER

\PRESCRIPTION ORDERS RENFLEXIS ® (INFLIXIMAB-ABDA) ALL DOSES WILL BE ROUNDED TO NEAREST 100 MG VIAL

Does patient have venous access? ☐ **YES** ☐ **NO**

If yes, what type: ☐ **MEDIPORT** ☐ **PIV** ☐ **PICC LINE** ☐ **OTHER:**_____

SELECT	DOSING OPTIONS	DOSE	ROUTE	FREQUENCY (POPULATE BELOW)	DURATION
	LOADING DOSES (WEIGHT BASED)	MG / KG	IV	0, 2, 6 WEEKS, THEN ONCE EVERY WEEKS	
	LOADING DOSES (FLAT DOSE)	MG	IV	0, 2, 6 WEEKS, THEN ONCE EVERY WEEKS	
	MAINTENANCE DOSE	5 MG / KG	IV	ONCE EVERY WEEKS	
	MAINTENANCE DOSE	10 MG / KG	IV	ONCE EVERY WEEKS	
	FLAT DOSE	MG	IV	ONCE EVERY WEEKS	

PREMEDS

SELECT	MEDICATION	DOSE	ROUTE
	BENADRYL		
	ACETAMINOPHEN		
	OXYGEN		
	Other:		
	Other:		
	Other:		

LABS

SELECT	LAB REQUESTED	WHEN	FREQUENCY
	BMP	( ) PRIOR ( ) POST	
	CMP	( ) PRIOR ( ) POST	
	BUN/CREATININE	( ) PRIOR ( ) POST	
	CRP:	( ) PRIOR ( ) POST	
	ESR:	( ) PRIOR ( ) POST	
	Other:	( ) PRIOR ( ) POST	

NOTES/INSTRUCTIONS/COMMENTS

_____

_____

FLUSHES: ☐ **10 mL NS Flush Syringe PRN** ☐ **Heparin 500 units/5 mL Flush Syringe PRN** ☐ **DO NOT ADMINISTER HEPARIN TO THIS PATIENT**

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 to the Outpatient Infusion Center at 1 (877) 249-1191.
PLEASE include copies of: H+P, OFFICE NOTES, LABS, ACTIVE MEDICATION PROFILE, and CURRENT INSURANCE INFORMATION in order for your referral to be processed.

CONNALLY MEMORIAL MEDICAL CENTER

☐ **STAT REFERRAL**

CONNALLY MEMORIAL
INFUSION CENTER
Phone: 830-477-0424
Fax: 1-877-249-1191

BONE MARROW STIMULATING AGENTS

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____DOB:_____

HT: _____in WT: _____kg Sex :( ) Male ( ) Female SSN:_____Home#:_____Cell#:_____

Address_____ City/State/Zip _____

Allergies:_____

Primary Insurance Name _____ Policy ID #: _____

Secondary Insurance Name_____ Policy ID #:_____

Physician Name_____ Contact Name _____ Contact Phone # _____

Address: _____City/State/Zip_____

NPI #:_____ Tax ID#:_____Fax #: _____

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

_____

Date of Diagnosis: _____

a) MAY BE SUBSTITUTED WITH BIOSIMILAR EQUIVILENT UNLESS OTHERWISE NOTED

PRESCRIPTION ORDERS

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

*Administer if Hemaglobin is < _____(lab value). Hold injection if Hemaglobin is ≥ to _____(lab value)

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY	DURATION
	Aranesp				
	Neulasta				
	Neupogen				
	Procrit				
	Other:				

NOTES:_____

_____

_____

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

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

Fax completed form to the Outpatient Infusion Center at 1 (877) 249-1191.
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CONNALLY MEMORIAL MEDICAL CENTER

☐ **STAT REFERRAL**

CONNALLY MEMORIAL
INFUSION CENTER
Phone: 830-477-0424
Fax: 1-877-249-1191

TYSABRI (NATALIZUMAB)

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____DOB:_____

HT: _____in WT: _____kg Sex :( ) Male ( ) Female SSN:_____Home#:_____Cell#:_____

Address_____ City/State/Zip _____

Allergies:_____

Primary Insurance Name _____ Policy ID #: _____

Secondary Insurance Name_____ Policy ID #:_____

Physician Name_____ Contact Name _____ Contact Phone # _____

Address: _____City/State/Zip_____

NPI #:_____ Tax ID#:_____Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD-10 Code plus Description)

_____

Date of Diagnosis: _____

Does the patient have venous access? O Yes ONo If Yes, what type? _____

If No, does patient need venous access? OYes 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

Drug	Dose	Route	Frequency	Duration
Tysabri	300mg	IV	Every 28 days	12 months

PREMEDS

SELECT BELOW	MEDICATION	DOSE	ROUTE
	NONE	NA	NA
	BENADRYL		
	ACETAMINOPHEN		
	OXYGEN		
	Other:		
	Other:		
	Other:		

LABS

SELECT BELOW	LAB REQUESTED	WHEN	FREQUENCY
X	JCV ANTIBODY	PRIOR	EVERY 6 MONTHS
	BMP	( ) PRIOR ( ) POST	
	CMP	( ) PRIOR ( ) POST	
	BUN/CREATININE	( ) PRIOR ( ) POST	
	CRP:	( ) PRIOR ( ) POST	
	ESR:	( ) PRIOR ( ) POST	
	Other:	( ) PRIOR ( ) POST	

NOTES:_____

_____

_____

FLUSHES: ☐ **10 mL NS Flush Syringe PRN** ☐ **Heparin 500 units/5 mL Flush Syringe PRN** ☐ **DO NOT ADMINISTER HEPARIN TO THIS PATIENT**

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 to the Outpatient Infusion Center at 1 (877) 249-1191.
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CONNALLY MEMORIAL MEDICAL CENTER

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CONNALLY MEMORIAL INFUSION CENTER
Phone: 830-477-0424
Fax: 1-877-249-1191

XOLAIR (OMALIZUMAB)

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____DOB:_____

HT: _____in WT: _____kg Sex :( ) Male ( ) Female SSN:_____Home#:_____Cell#:_____

Address_____ City/State/Zip _____

Allergies:_____

Primary Insurance Name _____ Policy ID #: _____

Secondary Insurance Name_____ Policy ID #:_____

Physician Name_____ Contact Name _____ Contact Phone # _____

Address: _____City/State/Zip_____

NPI #:_____ Tax ID#:_____Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD-10 Code plus Description)

_____

Date of Diagnosis: _____

PRESCRIPTION ORDERS

Drug	Dose	Route	Frequency	Duration
XOLAIR		**SQ**	**Every_____days**	**12 months**

PREMEDS

SELECT BELOW	MEDICATION	DOSE	ROUTE
	NONE	**NA**	**NA**
	BENADRYL		
	ACETAMINOPHEN		
	OXYGEN		
	Other:		
	Other:		
	Other:		

LABS

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

NOTES:_____

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

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

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CONNALLY MEMORIAL MEDICAL CENTER

☐ **STAT REFERRAL**

CONNALLY MEMORIAL
INFUSION CENTER
Phone: 830-477-0424
Fax: 1-877-249-1191

SIMPONI ARIA (GOLIMUMAB)

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____DOB:_____

HT: _____in WT: _____kg Sex :( ) Male ( ) Female SSN:_____Home#:_____Cell#:_____

Address_____ City/State/Zip _____

Allergies:_____

Primary Insurance Name _____ Policy ID #: _____

Secondary Insurance Name_____ Policy ID #:_____

Physician Name_____ Contact Name _____ Contact Phone # _____

Address: _____City/State/Zip_____

NPI #:_____ Tax ID#:_____Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD-10 Code plus Description)

_____

Date of Diagnosis: _____

Does the patient have venous access? O Yes ONo If Yes, what type? _____

If No, does patient need venous access? OYes 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

Drug	Dose	Route	Frequency	Duration
SIMPONI ARIA		**IV**	**Every_____weeks**	**12 months**

PREMEDS

SELECT BELOW	MEDICATION	DOSE	ROUTE
	NONE	**NA**	**NA**
	BENADRYL		
	ACETAMINOPHEN		
	OXYGEN		
	Other:		
	Other:		
	Other:		

LABS

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

NOTES:_____

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

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

Fax completed form to the Outpatient Infusion Center at 1 (877) 249-1191.
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CONNALLY MEMORIAL MEDICAL CENTER

CONNALLY MEMORIAL
INFUSION CENTER
Phone: 830-477-0424
Fax: 1-877-249-1191

☐ **STAT REFERRAL**

ORENCIA (ABATACEPT)

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____DOB:_____

HT: _____in WT: _____kg Sex :( ) Male ( ) Female SSN:_____Home#:_____Cell#:_____

Address_____ City/State/Zip _____

Allergies:_____

Primary Insurance Name _____ Policy ID #: _____

Secondary Insurance Name_____ Policy ID #:_____

Physician Name_____ Contact Name _____ Contact Phone # _____

Address: _____City/State/Zip_____

NPI #:_____ Tax ID#:_____Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD-10 Code plus Description)

_____

Date of Diagnosis: _____

Does the patient have venous access? O Yes ONo If Yes, what type? _____

If No, does patient need venous access? OYes 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

SELECT	Drug	Dose	Route	Frequency	Duration
	ORENCIA (LOADING DOSES)		IV	0, 2, 4 weeks, then once every 4 weeks	12 months
	ORENCIA	500 mg	IV	Every 4 weeks	12 months
	ORENCIA	750 mg	IV	Every 4 weeks	12 months
	ORENCIA	1000 mg	IV	Every 4 weeks	12 months

PREMEDS

SELECT BELOW	MEDICATION	DOSE	ROUTE
	NONE	NA	NA
	BENADRYL		
	ACETAMINOPHEN		
	OXYGEN		
	Other:		
	Other:		
	Other:		

LABS

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

NOTES:_____

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

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

Fax completed form to the Outpatient Infusion Center at 1 (877) 249-1191.
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CONNALLY MEMORIAL MEDICAL CENTER

☐ **STAT REFERRAL**

CONNALLY MEMORIAL INFUSION CENTER
Phone: 830-477-0424
Fax: 1-877-249-1191

VENOFER (IRON SUCROSE)

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____DOB:_____

HT: _____in WT: _____kg Sex :( ) Male ( ) Female SSN:_____Home#:_____Cell#:_____

Address_____ City/State/Zip _____

Allergies:_____

Primary Insurance Name _____ Policy ID #: _____

Secondary Insurance Name_____ Policy ID #:_____

Physician Name_____ Contact Name _____ Contact Phone # _____

Address: _____City/State/Zip_____

NPI #:_____ Tax ID#:_____Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD-10 Code plus Description)

_____

Date of Diagnosis: _____

Does the patient have venous access? O Yes ONo If Yes, what type? _____

If No, does patient need venous access? OYes O No If Yes, hospital will make arrangements.

PRESCRIPTION ORDERS

Drug	Dose	Route	Frequency	Duration
VENOFER		IV	Every_____days	

PREMEDS

SELECT BELOW	MEDICATION	DOSE	ROUTE
	NONE	NA	NA
	BENADRYL	50mg	IV
	ACETAMINOPHEN		
	OXYGEN		
	EPINEPHRINE	0.3mg / 0.3ml	IM
	SOLU-MEDROL	125mg	IV
	Other:		

LABS

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

NOTES:_____

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

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

Fax completed form to the Outpatient Infusion Center at 1 (877) 249-1191.
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CONNALLY MEMORIAL MEDICAL CENTER

☐ **STAT REFERRAL**

CONNALLY MEMORIAL INFUSION CENTER
Phone: 830-477-0424
Fax: 1-877-249-1191

OCREVUS (OCRELIZUMAB)

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____DOB:_____

HT: _____in WT: _____kg Sex :( ) Male ( ) Female SSN:_____Home#:_____Cell#:_____

Address_____ City/State/Zip _____

Allergies:_____

Primary Insurance Name _____ Policy ID #: _____

Secondary Insurance Name_____ Policy ID #:_____

Physician Name_____ Contact Name _____ Contact Phone # _____

Address: _____City/State/Zip_____

NPI #:_____ Tax ID#:_____Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD-10 Code plus Description)

_____

Date of Diagnosis: _____

Does the patient have venous access? ○ Yes ○No If Yes, what type? _____

If No, does patient need venous access? ○Yes ○ 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

SELECT	Drug	Dose	Route	Frequency	Duration
	OCREVUS (OCRELIZUMAB) (LOADING DOSES)	300mg	IV	300 mg IV at 0, 2 weeks, then 600mg IV once every 6 months	12 months
	OCREVUS (OCRELIZUMAB) (MAINTANENCE DOSES)	600 mg	IV	Every 6 months	12 months

PREMEDS

SELECT BELOW	MEDICATION	DOSE	ROUTE
	NONE	NA	NA
	BENADRYL		
	ACETAMINOPHEN		
	OXYGEN		
	Other:		
	Other:		
	Other:		

LABS

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

NOTES:_____

_____

_____

FLUSHES: ☐ **10 mL NS Flush Syringe PRN** ☐ **Heparin 500 units/5 mL Flush Syringe PRN** ☐ **DO NOT ADMINISTER HEPARIN TO THIS PATIENT**

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 to the Outpatient Infusion Center at 1 (877) 249-1191.
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CONNALLY MEMORIAL MEDICAL CENTER

☐ **STAT REFERRAL**

CONNALLY MEMORIAL
INFUSION CENTER
Phone: 830-477-0424
Fax: 1-877-249-1191

REMICADE (INFLIXIMAB) ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____DOB:_____

HT: _____in WT: _____kg Sex :( ) Male ( ) Female SSN:_____Home#:_____Cell#:_____

Address_____ City/State/Zip _____

Allergies:_____

Primary Insurance Name _____ Policy ID #: _____

Secondary Insurance Name_____ Policy ID #:_____

Physician Name_____ Contact Name _____ Contact Phone # _____

Address: _____City/State/Zip_____

NPI #:_____ Tax ID#:_____Fax #: _____

STATEMENT OF MEDICAL NECESSITY ICD-10 Code plus Description

_____

PERTINENT MEDICAL HISTORY **1)** TB test performed? ○ Yes ○ No Results,_____

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

4) Patient previously treated with Remicade? ○ Yes ○ No Date: _____5) Hep-B antigen surface antibody test? ○ Yes ○ No Date: _____

a) ALL IV ACCESSES WILL BE FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL PROTOCOL
b) INFLIXIMAB WILL BE ADMINISTERED IN NS 0.9% 250 ML OVER NO LESS THAN 2 HOURS WITH A 1.2 MICRON FILTER
c) MAY BE SUBSTITUTED WITH BIOSIMILAR EQUIVALENT, INFLECTRA, UNLESS OTHERWISE NOTED

PRESCRIPTION ORDERS: REMICADE® (INFLIXIMAB) ALL DOSES WILL BE ROUNDED TO NEAREST 100 MG VIAL

Does patient have venous access? ☐ **YES** ☐ **NO**

If yes, what type: ☐ **MEDIPORT** ☐ **PIV** ☐ **PICC LINE** ☐ **OTHER:**_____

SELECT	DOSING OPTIONS	DOSE	ROUTE	FREQUENCY (POPULATE BELOW)	DURATION
	LOADING DOSES (WEIGHT BASED)	MG / KG	IV	0, 2, 6 WEEKS, THEN ONCE EVERY WEEKS	
	LOADING DOSES (FLAT DOSE)	MG	IV	0, 2, 6 WEEKS, THEN ONCE EVERY WEEKS	
	MAINTENANCE DOSE	5 MG / KG	IV	ONCE EVERY WEEKS	
	MAINTENANCE DOSE	10 MG / KG	IV	ONCE EVERY WEEKS	
	FLAT DOSE	MG	IV	ONCE EVERY WEEKS	

PREMEDS

SELECT	MEDICATION	DOSE	ROUTE
	BENADRYL		
	ACETAMINOPHEN		
	OXYGEN		
	Other:		
	Other:		
	Other:		

LABS

SELECT	LAB REQUESTED	WHEN	FREQUENCY
	BMP	( ) PRIOR ( ) POST	
	CMP	( ) PRIOR ( ) POST	
	BUN/CREATININE	( ) PRIOR ( ) POST	
	CRP:	( ) PRIOR ( ) POST	
	ESR:	( ) PRIOR ( ) POST	
	Other:	( ) PRIOR ( ) POST	

NOTES/INSTRUCTIONS/COMMENTS

_____

_____

FLUSHES: ☐ **10 mL NS Flush Syringe PRN** ☐ **Heparin 500 units/5 mL Flush Syringe PRN** ☐ **DO NOT ADMINISTER HEPARIN TO THIS PATIENT**

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 to the Outpatient Infusion Center at 1 (877) 249-1191.
PLEASE include copies of: H+P, OFFICE NOTES, LABS, ACTIVE MEDICATION PROFILE, and CURRENT INSURANCE INFORMATION in order for your referral to be processed.

CONNALLY MEMORIAL MEDICAL CENTER

☐ **STAT REFERRAL**

CONNALLY MEMORIAL INFUSION CENTER
Phone: 830-477-0424
Fax: 1-877-249-1191

INJECTAFER (FERUMOXYTOL)

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____DOB:_____

HT: _____in WT: _____kg Sex :( ) Male ( ) Female SSN:_____Home#:_____Cell#:_____

Address_____ City/State/Zip _____

Allergies:_____

Primary Insurance Name _____ Policy ID #: _____

Secondary Insurance Name_____ Policy ID #:_____

Physician Name_____ Contact Name _____ Contact Phone # _____

Address: _____City/State/Zip_____

NPI #:_____ Tax ID#:_____Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD-10 Code plus Description)

_____

Date of Diagnosis: _____

Does the patient have venous access? O Yes ONo If Yes, what type? _____

If No, does patient need venous access? OYes O No If Yes, hospital will make arrangements.

PRESCRIPTION ORDERS

Drug	Dose	Route	Frequency	Duration
INJECTAFER	750 MG	IV	Every 7 days	X 2 doses

PREMEDS

SELECT BELOW	MEDICATION	DOSE	ROUTE
	NONE	NA	NA
	BENADRYL	50mg	IV
	ACETAMINOPHEN		
	OXYGEN		
	EPINEPHRINE	0.3mg / 0.3ml	IM
	SOLU-MEDROL	125mg	IV
	Other:		

LABS

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

NOTES:_____

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

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

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