

# **BLOOD PRODUCT TRANSFUSION ORDER FORM**

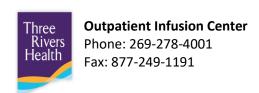
	ENT INFORMATION								_
	Name:								
HI:_	in WT:	_kg Sex:( )Male	( )Fe	male Aller	gies: ( ) NKDA,				
Physi	cian Name				Contact Name		Contact Ph	none #	
	:								
STAT	EMENT OF MEDICAL NEC	<u>ESSITY</u>							
Prima	ary Diagnosis: (ICD 10 CC	DDE + DESCRIPT	TION)			Secondary Diagr	iosis: (ICD 10 CODE +	DESCRIPTION)	
	INENT MEDICAL HISTORY								
Does	patient have venous access?	YES	NO If y	yes, what ty	pe 🗌 MEDIPORT 🗌	PIV PICC L	NE OTHER:		
1) Is	the patient incontinent?	O Yes O No 2	2) Is the	patient am	bulatory? O Yes	O No			
NOT	ES:								
B) 25( C) TU	L MEDIPORTS / IV ACCESS 0 cc BAG OF 0.9% NS MAY IBING WILL BE FLUSHED W ·H MUST BE COMPLETED V	BE HUNG WITH EA /ITH 0.9% NS UNTI	ACH BLO L TUBIN	OOD PRODU IG IS PINK T	CT TRANSFUSION INGED OR CLEAR				
TYPE	, CROSSMATCH, AND TRA	NSFUSE:				LABS			
LECT	# of UNITS		PRODUCT			SELECT	LAB REQ	UESTED	WHEN
		FRESH FROZE	N PLASI	MA			NONE		NA
		LEUKO REDUC	ED PRE	3Cs			ВМР		( ) PRIOR ( ) POST
		LEUKO REDUC	ED IRR	ADITED PRE	BCs		CMP		( ) PRIOR ( ) POST
		LEUKO REDUC	ED PLA	TELETS			CBC w/ DIFF		( ) PRIOR ( ) POST
		LEUKO REDUC	ED IRR	ADIATED PL	ATELETS		H+H:		( ) PRIOR ( ) POST
		Other:					Other:		( ) PRIOR ( ) POST
PREN	/IEDS	<b>I</b>				NOTES/	INSTRUCTIONS/COMME	ENTS	П
LECT	MEDICATION	D	OSE	ROUTE	FREQUENCY				
	NONE	NA		NA	NA				
	BENADRYL								
	ACETAMINOPHEN								
	OXYGEN								
	LASIX	2	0mg	IV					<del></del>
	Other:								
DIET	TADY DESTRICTIONS	/lf name place	ماممان		<u> </u>				
DIE	TARY RESTRICTIONS	(II florie, pieas	e maic	Jale)					
FLUS	SHES: 🔲 10 mL NS FI	ush Syringe PRN	1 🗌	Heparin 5	00 units/5 mL Flus	h Syringe PRN	DO NOT ADMII	NISTER HEPARIN	TO THIS PATIENT
Phys	sician's Signature						Time	Date	
*Sign	ature Must Be Clear and Leg	ible							
Cosi	gnature (If Required)						Time	Date	
	ature Must Be Clear and Leg								



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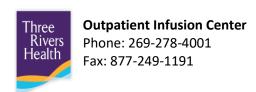
# ENTYVIO (VEDOLIZUMAB) ORDER FORM

PATIE	ENT INFORMATION								
	lame:					MI DOB:			
HT: _	in WT: kg Sex :(	) Male ( ) Female Alle	rgies: ( ) NKI	DA,					
Physic	cian Name		_ Contact Na	me	Con	tact Phone #			
NPI#		Tax ID#			Fax #:				
Prima	EMENT OF MEDICAL NECESSITY  ary Diagnosis: ICD-10 Code plus De  INENT MEDICAL HISTORY 1) TB te				Results,				
2) Pat	ient diagnosed with Congestive Heart F	ailure? O Yes O No 3) L	iver function to	est normal? O Y	es O No				
,	ient previously treated with Entyvio? O	•				Yes O No Date:			
b) EN	. MEDIPORTS / IV ACCESSES WILL B TYVIO (VEDOLIZUMAB) WILL BE ADM L LINES WILL BE FLUSHED WITH 30 I	IINISTERED IN NS 0.9% 250	ML OVER N	O LESS THAN 3		RON FILTER			
	CRIPTION ORDERS: ENTYVIO (VED)								
	. —	PIV PICC LINE	□ оть	JED:					
				ILIX.					
ELECT	DOSING OPTIONS  LOADING DOSES	DOSE 300 MG	ROUTE	0.2.6.WEE	FREQUENCY (POPULA	<u> </u>	DURATION		
	MAINTENANCE DOSE	300 MG	IV	0, 2, 6 WEEKS, THEN ONCE EVERY 8 WEEKS  ONCE EVERY 8 WEEKS					
		300 MG	IV		KT 0 WEEKS				
PREN	MEDICATION	DOSE	ROUTE	LABS SELECT	LAB REQUESTED	WHEN	FREQUENCY		
	NONE	NA	NA		NONE	NA	NA		
	BENADRYL				ВМР	( ) PRIOR ( ) POST			
	ACETAMINOPHEN				CMP	( ) PRIOR ( ) POST			
	OXYGEN				BUN/CREATININE	( ) PRIOR ( ) POST			
	Other:				CRP:	( ) PRIOR ( ) POST			
	Other:				ESR:	( ) PRIOR ( ) POST			
	Other:				Other:	( ) PRIOR ( ) POST			
NOTE	S/INSTRUCTIONS/COMMENTS								
FLUS	SHES: 10 mL NS Flush Syrin	ge PRN  Heparin :	500 units/5 ı	mL Flush Syri	nge PRN DO NOT A	ADMINISTER HEPARIN TO	THIS PATIENT		
Phvs	ician's Signature				Time	Date_			
	ature Must Be Clear and Legible								
	gnature (If Required)				Time	Date			



#### **GENERAL IV ORDER FORM**

PATIENT INFOR						
					N	
HI:	in WI:kg Se	x:( ) Male (	) Female Allergies: ( ) N	KDA,		
Physician Name			Contact N	Jame	Contact Phone #	
					Fax #:	
	OF MEDICAL NECESS					
·			M	Cocondon, F	diagnosia: /ICD 10 CODE : DEC	PDIDTION)
Primary Diagno	osis: (ICD 10 CODE + I	JESCRIPTIO	N)	Secondary L	liagnosis: (ICD 10 CODE + DESC	CRIPTION)
		7				
PRESCRIPTIO		_ YES _	NO If yes, what type [	MEDIPORTF	PIV PICC LINE OTHER:	
		SSES WILL BE	FLUSHED WITH HEPARIN	OR SALINE PER HOSPIT	AL PROTOCOL PRN	
b) CON	ISULT HOSPITAL PHARI	MACY TO MON	IITOR AND ADJUST THERA		EIVING VANCOMYCIN OR GENTAI	
NOTE: For patie	ents with central venous	access, pleas	e select: D/C AFTER I	LAST DOSE	PERFORM DAILY/WEEKLY IV SITE	CARE PRN UNTIL DISCHARGED
	DRUG 1		DOSE	ROUTE	FREQUENCY	DURATION
	DRUG 2		DOSE	ROUTE	FREQUENCY	DURATION
	DDUG A		2005	DOUTE	EDECUENCY.	BUBATION
	DRUG 3		DOSE	ROUTE	FREQUENCY	DURATION
	DRUG 4		DOSE	ROUTE	FREQUENCY	DURATION
LABS		•		NOTES/INSTF	RUCTIONS/OTHER	
SELECT BELOW	LAB REQUESTED		FREQUENCY	- Per	form daily/weekly IV site ca	re PRN until discharged
	NONE	NA				
	CBC w/ Diff				minister Cath-Flo Activase 2 ggish or occluded	amg IVP PRN if line becom
	CMP			Siuş	ggish of occided	
	BUN/CREATININE					
	ESR					
	CRP					
	СРК					
	Other:					
	Other:					
	CPK Other:					
Physician's Si	gnature		Heparin 500 units/5		RN DO NOT ADMINISTE	R HEPARIN TO THIS PATIE  Date
*Signature Must	Be Clear and Legible					
Cosignature (I	f Required) Be Clear and Legible				Time	Date



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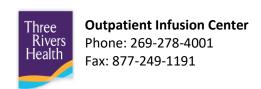
## **HYDRATION ORDER FORM**

PATIENT INFOR	MATION						
Last Name:						DOB:	
HT:	in WT:kg Se	x:( ) Male ( ) Female Allergies: (	) NKDA,				
Physician Name_		Conta	act Name	Conta	 act Phone #		
		Tax ID#:					
STATEMENT OF	MEDICAL NECESSITY						
Primary Diagno	osis: (ICD 10 CODE) _				Date of Diagr	nosis:	
Does patient hav	e venous access?	YES NO If yes, what typ	pe MEDIP	ORT PIV PICC LINE	OTHER:		
a) ALL	MEDIPORTS/IV ACCESS	S WILL BE ACCESSED AND FLUSHED	WITH SALINE	OR HEPARIN PER HOSPITAL PROTO	COL		
DO NOT ADMIN	NISTER HEPARIN TO TH	HIS PATIENT					
PRESCRIPTI	ON ORDERS FOR I	HYDRATION Select the f	luid requeste	ed AND the corresponding rate be	elow		
	RMAL SALINE		-	ED 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				
	VEN OVER 1 HOUR		□ BOLUS - GIVEN OVER 1 HOUR				
□ Over 2 hour		nour	□ Over 2 hours @ mls/hour				
□ Over 4 hour	s @ mls/h	nour	□ Over 4 h	ours @ mls/hour			
☐ Other:	mls/ł	nour	☐ Other:	mls/hour			
□ <u>OTHER (PLI</u>	EASE SPECIFY DRUG	G, RATE, FREQUENCY, AND DUR	ATION BELO	<u>W):</u>			
LABS:			N	OTES/INSTRUCTIONS/COMM	ENTS		
SELECT BELOW	LAB REQUESTED	FREQUENCY					
	NONE	NONE					
	CBC w/ Diff	() PRIOR () POST					
	ВМР	() PRIOR () POST					
	CMP	() PRIOR () POST					
	BUN/CREATININE	() PRIOR () POST					
	Other:	() PRIOR () POST					
51.1101150 F	7.40					D 4 DIN TO THE D 4 TIENT	
FLUSHES:	10 mL NS Flush Sy	rringe PRN 🔲 Heparin 500 uni	ts/5 mL Flusi	h Syringe PRN <u>DO NOT AI</u>	<u>DMINISTER HE</u>	PARIN TO THIS PATIENT	
Physician's Si *Signature Must	<b>gnature</b> Be Clear and Legible			Time		Date	
-	•			<b>-</b> -		ъ.	
Cosignature (I	f <b>Required)</b> Be Clear and Legible			Time		Date	



#### **INTRAVENOUS IMMUNO GLOBULIN ORDER FORM**

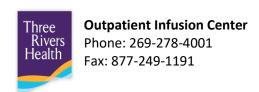
PATI	ENT INFORMATION									
	Name:									
HT:_	in WT: kg Sex:( ) Male	( )Fe	male Allerg	ies: ( ) NKD	Α,					
Phys	ician Name			Contact Nan	ne		Conta	ct Phone #		
NPI#	#:	Tax ID#:				Fax #:				
STA	TEMENT OF MEDICAL NECESSITY									
Prim	Primary Diagnosis: ICD 10 + Description: Date of Diagnos									
PRE	SCRIPTION ORDERS: IVIG (DOSES WILL BE RO	UNDED 1	TO NEAREST 10 G	M INCREMENT	TO FI IM	INATE WAS	STF)			
	s patient have venous access?							OTHER.		
2000	a) ALL MEDIPORTS/IV ACCESS WILL BE A									
DDE	FERRED BRAND :									
PKE	FERRED BRAIND .									
	<u>DUE TO LIMITED ME</u>	DICA	TION AVAIL	ABILITY S	<u>USBTI</u>	TUTION	I MAY APPLY PER HOSPIT	AL PROTOCOL		
SELECT	DOSE		ROUTE		RATE		REPEAT E	VERY	$\neg$	DURATION
	MG /	KG								
	GRAM /	KG								
	GRAM(s) (TOT								_	
225		AL)				1450				
SELECT	MEDS MEDICATION		DOSE	ROUTE	s	LABS ELECT	LAB REQUESTED	WHEN	·	FREQUENCY
	BENADRYL						ВМР	( ) PRIOR ( ) I		
	ACETAMINOPHEN						CMP	( ) PRIOR ( ) I	OST	
	SOLUMEDROL						BUN/CREATININE	( ) PRIOR ( ) I	OST	
	Other:						Other:	( ) PRIOR ( ) I	OST	
	Other:						Other:	() PRIOR () F	OST	_
TITR	ATION									
	ATTACHED PROTOCOL (Check if preferred pr	otocol	l is establishe	ed and subm	it alon	g with o	order form)			
_	nfusion atmg/kg/min for 30 min mg/kg/min, then to max rate of				ase ev	ery 30 :	minutes as follows:	_mg/kg/min, th	en	mg/kg/min,
	te for pre-existing renal insufficiency or				cg/mir	1				
	ES/INSTRUCTIONS/COMMENTS									
	20/110 TK00 T10110/00 IIIIII 21110									
ELLIG	SHES: 10 mL NS Flush Syringe PRN	Hono	rin 500 unital	5 ml Eluch (	Suring	DDN	DO NOT ADMINISTER HE	DADIN TO THIS DA	TIENT	
FLU	SHES.   IV IIIE NO Flush Syninge FRN	пера	iiii 300 uiiits/	J IIIL FIUSII (	Syringe	FINN	DO NOT ADMINISTER HE	FARIN TO THIS FA	<u> </u>	
Phys	sician's Signature						Time		Date	
	nature Must Be Clear and Legible									
Cos	ignature (If Required)						Time		Date	
*Sign	nature Must Be Clear and Legibl									



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# PROLIA (DENOSUMAB) ORDER FORM

	FROL	LIA (DENOSUWAB) OKI	DER FORIN	
PATIENT INFORMATION				
HT: in WT:	kg Sex :( ) Male ( ) Female Alle	rgies: ( ) NKDA,		
Physician Name		Contact Name	Contact	Phone #
				T Hone #
STATEMENT OF MEDICA Primary Diagnosis: (ICD-10 C				
Primary Diagnosis: (ICD-10 C	ODE + DESCRIPTION)		Date of D	agnosis:
PRESCRIPTION ORDER	3			
I KLOOKII HON OKDEK	<u>.</u>			
	DDOLLA (DEN	100UMAD) 00	OUDOUTANEOUS	
	•	IOSUMAB) 60 mg/ml, NCE EVERY 6 MONT		
	GIVE OI	NCE EVERY 6 MONI	HS X 1 YEAR	
PROLIA (DENOSUMAB)	PATIENTS MUST FALL WITHIN ONE	OF THE LISTED CATEGO	RIES BELOW	
	SIS – (Standard Documentation Requi		IIIIO DELOTI	
,				
CALCIUM MUS	ST BE CHECKED WITHIN THE LAST 3	30 DAYS OF THE APPOIN	TMENT	
	TY/DEXA SCAN WITHIN 2 YEARS OF T			
H+P OR OFFICE  APPOINTMEN	CE NOTES LISTING THE DIAGNOSIS (	OF OSTEOPOROSIS IN T	HE PATIENT RECORD DATE	WITHIN 1 YEAR PRIOR TO
	I ENT MEDICATIONS MUST BE DOCUM	IENTED IN DATIENT'S ME	DICAL RECORD (Evamples:	Oral calcium Vitamin D)
• I MONOOMA	INT MEDICATIONS MOST BE DOCUM	ILINIED IN FAILENT O MIL	DIOAL NEOOND (Examples.	Oral calcium, Vitaliim D)
2) MEN AT HIGH	RISK OF FRACTURE RECEIVING AN	DROGEN DEPRIVATION	THERAPY FOR NONMETAST	ATIC PROSTATE CANCER
,	TO INCREASE BONE MASS IN WOME	N AT HIGH RISK FOR FR	ACTURE RECEIVING AROMA	TASE INHIBITOR THERAPY FOR
BREAST CAN	CER			
*OSTFOPENIA IS NOT A	N APPROVED DIAGNOSIS FOR PROL	I IA (DENOSUMAR), PATII	NTS WITH IMPRESSIONS O	F OSTFOPFNIA MUST HAVE AN
		•		IMENTATION A PREVIOUS FRAGILITY
FRACTURE				
LARC NEEDED, CALCILI	M if provide to reculte met provided with	thin loot 20 days)		
LADS NEEDED: CALCIU	M if previous results not provided wit	tnin iast so days)		
SPECIAL NOTE: PROLIA	(DENOSUMAB) IS CONTRAINDICAT	ED IN PATIENTS WITH H	YPOCALCEMIA	
Physician's Signature _			Time	Date
*Signature Must Be Clear and	Legible			
Cosignature (If Required	)		Time	Date
*Signature Must Re Clear and	I Legible		<del></del>	



## RECLAST 5 mg / 100 ml IV ORDER FORM

PATIENT INFORMATION			
Last Name:	First Name:		MI DOB:
HT: in WT: kg Sex :( ) Male	e ( ) Female Allergies: ( ) NKDA,		
Physician Name	Contact Name	Contact Ph	ione #
NPI #:	Tax ID#:	Fax #:	
STATEMENT OF MEDICAL NECESSITY Primary Diagnosis: (ICD-10 CODE + DESCRIPTION)		Date of Diag	nosis:
Data actions house versus access?		24.0 0.2 mg.	
Does patient have venous access?			
If yes, what type:			
a) ALL MEDIPORTS/IV ACCESS WILL BE ACCES	SSED AND FLUSHED WITH SALINE OR HEP	ARIN PER HOSPITAL PROTOCOL	
PRESCRIPTION ORDERS			
	NISTER RECLAST (ZOLEDRONIC OVER NO LESS THAN 15 MINUTES ONTS MUST FALL WITHIN ONE OF TH	S ONE TIME A YEAR	. <u>OW:</u>
-	ocumentation Requirements Listed B		
<ul> <li>BONE DENSITY/DEXA SCAN WITH</li> <li>H+P OR OFFICE NOTES LISTING TAPPOINTMENT</li> <li>PRIOR/CURRENT MEDICATIONS URECORD. Examples: Oral calcium,</li> </ul>	F GLUCOCORTICOID-INDUCED OSTEOP	HERWISE ONE MUST BE PERFO THE PATIENT RECORD DATED W TEOPOROSIS MUST BE DOCUMI	VITHIN 1 YEAR PRIOR TO
3) TREATMENT OF PAGET'S DISEAS	E OF BONE IN MEN AND WOMEN		
LABS NEEDED: BUN and CREATININE	(if previous results not provided v	vithin last 30 days)	
		in in in the state of the state	
NOTE: RECLAST (ZOLEDRONIC ACID) IS CO	NTRAINDICATED IN PATIENTS WITH Cr	CI < 35 ml/min	
FLUSHES: 10 mL NS Flush Syringe PRN	Heparin 500 units/5 mL Flush Syringe PRN	DO NOT ADMINISTER HEPAR	IN TO THIS PATIENT
		_	_
Physician's Signature*Signature Must Be Clear and Legible		Time	Date
organicate intest De Oreal alla Legible			
Cosignature (If Required)_ *Signature Must Be Clear and Legible		Time	Date



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#### **REMICADE (INFLIXIMAB) ORDER FORM**

PATIEN	IT INFORMATION						
						MI DOB:	
HT:	in WT:kg Sex:( ) Ma	le ( ) Female Alle	rgies: ( ) NKI	DA,			
	an Name						
NPI #:_		Tax ID#			Fax #: _		
STATE	EMENT OF MEDICAL NECESSITY ICD	0-10 Code plus Des	cription				
<u>PERTI</u>	NENT MEDICAL HISTORY 1) TB test p	performed? O Yes C	No Results	,			
2) Patie	nt diagnosed with Congestive Heart Failure?	O Yes O No 3) L	iver function to	est normal? O Yes O No			
4) Patie	nt previously treated with Remicade? O Yes	s O No Date:	5)	Hep-B antigen surface antib	oody test? O Yes	O No Date:	_
b) INFL	IV ACCESSES WILL BE FLUSHED WITH SA IXIMAB WILL BE ADMINISTERED IN NS 0.9 BE SUBSTITUTED WITH BIOSIMILAR EQU	% 250 ML OVER NO	LESS THAN	2 HOURS WITH A 1.2 MICI	RON FILTER		
	CRIPTION ORDERS: REMICADE® (IN	_	SES WILL B	E ROUNDED TO NEARES	T 100 MG VIAL		
•	atient have venous access? YES			150			
If yes, \	what type: MEDIPORT P	IV PICC LINE	∐ ОТН	HER:			
ELECT	DOSING OPTIONS	DOSE	ROUTE	FF	REQUENCY (POPULA	ATE BELOW)	DURATION
	LOADING DOSES (WEIGHT BASED)	MG / KG	IV	0, 2, 6 WEEKS, THEN O	NCE EVERY	WEEKS	
	LOADING DOSES (FLAT DOSE)	MG	IV	0, 2, 6 WEEKS, THEN O	NCE 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		
PREME		<u> </u>	l	LABS			
LECT	MEDICATION BENADRYL	DOSE	ROUTE	SELECT LA	AB REQUESTED	WHEN ( ) PRIOR ( ) POST	FREQUENCY
	ACETAMINOPHEN			CMP		( ) PRIOR ( ) POST	
					EATININE	. ,	
	OXYGEN			BUN/CR	EATININE	( ) PRIOR ( ) POST	
	Other:			CRP:		( ) PRIOR ( ) POST	
	Other:			ESR:		( ) PRIOR ( ) POST	
	Other:			Other:		( ) PRIOR ( ) POST	
NOTES	/INSTRUCTIONS/COMMENTS						
FLUSH	ES: 10 mL NS Flush Syringe PRN	Heparin 500 unit	s/5 mL Flush	Syringe PRN DON	IOT ADMINISTER	HEPARIN TO THIS PATIENT	
	cian's Signature ure Must Be Clear and Legible				Time	Date	
-	nature (If Required)				Time	Date	
	ure Must Be Clear and Legible				111110	Date	<del></del>



#### **BONE MARROW STIMULATING AGENTS**

		DONE MAIN	MOW OTHIOLATING	AOLITIO		
ATIENT INFO						
	· W.T.					
II:	_ in WT: kg Sex :( ) Mal	le ( ) Female Allergies:	( ) NKDA,			
hysician Name	)	Cor	ntact Name		Contact Phone #	
IPI #:		Tax ID#:		Fax	<b>&lt;</b> #:	
STATEMEN	NT OF MEDICAL NECESS	ITY Primary Diagnosis: (I	CD-10 Code plus Descript	on)		
•	sis: Y BE SUBSTITUTED WITH BIO	SIMILAR EQUIVILENT L	JNLESS OTHERWISE I	NOTED		
RESCRIP	TION ORDERS					
	C prior to each injection (s)					
Administer	if Hemaglobin is <	(lab value). Hold	d injection if Hemag	lobin is ≥ to _	(lab value	)
SELECT	MEDICAT	ION	DOSE	ROUTE	FREQUENCY	DURATION
	Aranesp					
	Neulasta					
	Neupogen					
	Procrit					
	Other:					
OTES:						
hysician's S	ignature			Time		Date
ignature Must	Be Clear and Legible					
ocianaturo /	(If Required)			Time		Date



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## **TYSABRI (NATALIZUMAB)**

PATIENT INF	ORMATION							
							MI DOB	
HT:	in WT:	kg Sex:( ) Male (	) Female A	llergies: ( ) NKD	DA,			
Discostation No.				0111			and and Discount H	
							ontact Phone #	
INF1#			I ax IL	J#		гах #		
STATEMI	ENT OF MED	ICAL NECESSITY						
		le plus Description)						
Date of Diagr	nosis:							
Does the pati	ent have venous a	ccess? O Yes ONo	If Yes, wh	at type?				
		access? OYes O No	If Yes, ho	spital will make a	arrangements.			
	IPTION ORDI							
•		access?						
-		IEDIPORT						
a) ALL MED	IPORTS/IV ACCE	SS WILL BE ACCESSE	D AND FLUS	SHED WITH SAL	LINE OR HEPA	RIN PER HOSPITAL PROT	OCOL	
Drug		Dose		Route	F	requency	Duration	ı
	Tysabri 300mg			IV	Every 28 days		12 months	
1,500511					o., _o, o			
PREMEDS					LABS			
LECT LOW	MEDIO	CATION	DOSE	ROUTE	SELECT BELOW	LAB REQUESTED	WHEN	FREQUENCY
NON	NE		NA	NA	Х	JCV ANTIBODY	PRIOR	EVERY 6 MONTH
BEN	NADRYL					BMP	( ) PRIOR ( ) POST	
ACE	TAMINOPHEN					CMP	( ) PRIOR ( ) POST	
OXY	/GEN					BUN/CREATININE	( ) PRIOR ( ) POST	
Oth	er:					CRP:	( ) PRIOR ( ) POST	
Oth						ESR:	( ) PRIOR ( ) POST	
Oth	er:					Other:	( ) PRIOR ( ) POST	
							<u>.</u>	<u> </u>
NOTES:_								
FLUSHES:	10 mL NS Flu	sh Syringe PRN 🔲 H	eparin 500 uı	nits/5 mL Flush	Syringe PRN	DO NOT ADMINISTER	HEPARIN TO THIS PATIENT	
Physician's *Signature M	s Signature ust Be Clear and L	eaible				Time	Date_	
		09.070				_	_	
Cosignatur *Signature M	<b>'e (If Required)_</b> ust Be Clear and L	eaible				Time	Date_	
oignature M	usi De Gledi dilû L	- сушт <del>с</del>						



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## XOLAIR (OMALIZUMAB)

			AULAIN (U	IVIALIZUIVI	<u>ND)</u>		
PATIENT	<u>INFORMATION</u>						
	e:						
HT:	in WT: kg Sex :( ) Male (	) Female A	llergies: ( ) NKDA				
Physician	Name		Contact Name	·	Cor	ntact Phone #	
	MENT OF MEDICAL NECESSITY	<u>(</u>					
Primary D	iagnosis: (ICD-10 Code plus Description)						
D-44 D:							
Date of Di	agnosis:						
PRESC	RIPTION ORDERS						
D	Dana		Davita		·	Dat:	
Drug	Dose		Route	Г	requency	Duration	on
XOLAI	ID.		SQ	Every	days	12 mon	the
AULAI			300	∟veiy_	days	12 111011	เมอ
PREMED		l poer	POUTE	LABS		MUEN	EDEOLIENOV
LECT LOW	MEDICATION	DOSE	ROUTE	SELECT BELOW	LAB REQUESTED	WHEN	FREQUENCY
١	NONE	NA	NA		NONE	NA	NA
E	BENADRYL				ВМР	( ) PRIOR ( ) POST	
A	ACETAMINOPHEN				CMP	( ) PRIOR ( ) POST	
(	DXYGEN				BUN/CREATININE	( ) PRIOR ( ) POST	
(	Other:				CRP:	( ) PRIOR ( ) POST	
(	Other:				ESR:	( ) PRIOR ( ) POST	
(	Other:				Other:	( ) PRIOR ( ) POST	
NOTES:	<u>.</u>						
Physicia	n's Signature				Time	Date	
•	e Must Be Clear and Legible						
Cosigna	ture (If Required)e Must Be Clear and Legible				Time	Date	
Signature	, mast bo oldar and Logiblo						



## **SIMPONI ARIA (GOLIMUMAB)**

Г: nysician PI #: <b>ТАТЕ</b>	in WT:kg	Sex :( ) Male ( )									
nysician PI#:	Name			, ( )							
า#: <b>TATE</b>											
TATE							Cont				
	Tax ID#:					Fax #:					
	MENT OF MEDICAL	NECESSITY									
	iagnosis: (ICD-10 Code plus	Description)									
	agnosis:										
	patient have venous access? s patient need venous acces		If Yes, what ty If Yes, hospita								
	RIPTION ORDERS	3: 0103 0110	11 1 C3, 1103ptt	ai wiii iiic	inc arre	angements.					
	tient have venous acces	ss? 🗌 YES	□ NO								
es, wl	hat type:   MEDIP	ORT 🗌 PI	IV PICC	LINE		OTHER:					
ALL ME	EDIPORTS/IV ACCESS W	ILL BE ACCESSED	AND FLUSHE	D WITH	SALIN	NE OR HEPA	ARIN PER HOSPITAL PROTO	COL			
	Drug	Dr	se		Ro	oute	Frequency		Di	ıration	
	Diug		Dose		Route		Trequency			<u>raration</u>	
SIM	IPONI ARIA				IV		Every weeks		12 months		
MEDS	<u> </u>					LABS					
T /	MEDICATION		DOSE	ROUTE		SELECT BELOW	LAB REQUESTED		WHEN	FREQUE	
N	NONE		NA	NA			NONE	NA		NA	
В	BENADRYL						ВМР	( ) PRIO	R ()POST		
Α	ACETAMINOPHEN						CMP	( ) PRIO	R ()POST		
C	DXYGEN						BUN/CREATININE	( ) PRIO	R ()POST		
C	Other:						CRP:	( ) PRIO	R ()POST		
	Other:						ESR:	( ) PRIO	R ()POST		
	Other:						Other:	( ) PRIO	R ( ) POST		
		L	ı			<u> </u>	1			1	
TES:											



# **ORENCIA (ABATACEPT)**

	TI INFORMATION  me:		First Name:			MI DOP:		
	in WT:kg Sex:( ) Male (							
	II WI Ng GGX.( ) Male (	) i cilialo	Allergies. ( ) Tenes	',				
Physicia	an Name		Contact Nam	e	Co	ntact Phone #		
NPI #:_		Ta:	x ID#:		Fax #: _			
CTAT	TMENT OF MEDICAL NECESSIT	v						
	Diagnosis: (ICD-10 Code plus Description)	<u>1</u>						
Data of	Diagnosis:							
Does th	e patient have venous access? O Yes ONo obes patient need venous access? OYes O No SCRIPTION ORDERS		what type? hospital will make arr	rangements.				
	patient have venous access?	ES	NO					
If yes,	what type:	PIV	PICC LINE	OTHER:				
	MEDIPORTS/IV ACCESS WILL BE ACCESS	ED AND FL						
SELEC.		050)	Dose	Route		requency	Duration	
	ORENCIA (LOADING DO	SES)		IV	0, 2, 4 weeks	s, then once every 4 weeks	12 month	
	ORENCIA		500 mg	IV	Eve	ery 4 weeks	12 month	
	ORENCIA		750 mg	IV	Every 4 weeks		12 month	
	ORENCIA		1000 mg	IV	Eve	ery 4 weeks	12 month	
PREME SELECT	DS MEDICATION	DOSE	ROUTE	LABS SELECT	LAB REQUESTED	WHEN	FREQUENCY	
BELOW	NONE	NA	NA NA	BELOW	NONE	NA NA	NA NA	
	BENADRYL	NA .	NA .		BMP	( ) PRIOR ( ) POST	NA .	
	ACETAMINOPHEN				CMP			
	OXYGEN				BUN/CREATININE	( ) PRIOR ( ) POST		
	Other:				CRP:	( ) PRIOR ( ) POST		
	Other:			I	ESR:	( ) PRIOR ( ) POST		
	Other:				Other:	( ) PRIOR ( ) POST		
NOTE	S:							
Physic	cian's Signature				Time	Date		
	ure Must Be Clear and Legible							
	nature (If Required) ure Must Be Clear and Legible				Time	Date		
Jiyriall	aro masi bo oloar ana Eegibie							



#### **VENOFER (IRON SUCROSE)**

PATIE	ENT INFORMATION		<u>-</u>	ENOI EN (IIIO)	N OOOKOO	<u>,,</u>		
				_ First Name:			MI DOB:_	
HT: _	in WT:	_kg Sex:( )Male	( ) Female Aller	gies: ( ) NKDA,				
Physic	cian Name			Contact Name		Conta	ct Phone #	
OT 1	TEMENT OF MEDIC		=1.7					
	TEMENT OF MEDIC ry Diagnosis: (ICD-10 Code		<u>  Y</u>					
	· · ·							
	of Diagnosis: the patient have venous acc		n If Yes what t	vne?				
	does patient need venous a			al will make arrange				
DDE	SCRIPTION ORDER	90						
r IXL	Drug		ose	Route		Frequency	Durat	ion
				1100.00				
	VENOFER			IV	Eve	ry days		
PREM	IFDe			<u> </u>	LADE			
LECT	MEDICAT	TON	DOSE	ROUTE	SELECT	LAB REQUESTED	WHEN	FREQUENCY
LOW	NONE		NA NA	NA NA	BELOW	NONE	NA NA	NA NA
	BENADRYL		50mg	IV		BMP	()PRIOR()POST	INA .
	ACETAMINOPHEN		- Coming	<del>  ''</del>		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	
	Other.					Other.	( )FRIOR ( )FOOT	
NOT	ES:							
NOT	E3							
Phvs	ician's Signature					Time	Date	
*Signa	ature Must Be Clear and Leg	gible						
Cosic	gnature (If Required)					Time	Date	
*Signa	ature Must Be Clear and Leg	gible						



STAT	REFERRAL
•	

# **OCREVUS (OCRELIZUMAB)**

PATIEN	IT INFORMATION							
	me:						MI DOB:	
HT:	in WT:	kg Sex :( ) Male (	) Female	Allergies: ( ) NKDA	,			
							tact Phone #	
NPI #:_			Tax	ID#:		Fax #:		
STAT	EMENT OF ME	DICAL NECESSITY						
	Diagnosis: (ICD-10 C		•					
	Diagnosis:							
		access? O Yes ONo us access? O Yes O No		hat type? ospital will make arra			<del></del>	
	SCRIPTION ORI		11 165, 110	ospitai wiii make am	angements.			
	patient have venou		S 🗌 NO	)				
If yes,	what type:	MEDIPORT F	PIV 🗌	PICC LINE [	OTHER:			
a) ALL	MEDIPORTS/IV ACC	CESS WILL BE ACCESSE	D AND FLU	SHED WITH SALIN	NE OR HEPAF	RIN PER HOSPITAL PROTO	OCOL	
SELEC		Drug		Dose	Route	Fr	equency	Duration
	OCRE (I	VUS (OCRELIZUMA OADING DOSES)	AB)	300mg	IV		2 weeks, then 600mg every 6 months	12 month
		VUS (OCRELIZUMA	AB)	600 mg	IV		y 6 months	12 month
	(MAI	NTANENCE DOSES	5)	_				
PREME		DICATION	DOSE	ROUTE	LABS SELECT	LAB REQUESTED	WHEN	FREQUENCY
BELOW		DICATION		ROUTE	BELOW	LAB REQUESTED		FREQUENCY
	NONE		NA	NA		NONE	NA	NA
	BENADRYL					ВМР	( ) PRIOR ( ) POST	
	ACETAMINOPHEN					CMP	( ) PRIOR ( ) POST	
	OXYGEN					BUN/CREATININE	( ) PRIOR ( ) POST	
	Other:					CRP:	( ) PRIOR ( ) POST	
	Other:					ESR:	( ) PRIOR ( ) POST	
	Other:					Other:	( ) PRIOR ( ) POST	
NOTE			•					1
NOTE	3:							
FLUSH	ES: 10 mL NS F	lush Syringe PRN	leparin 500 ι	ınits/5 mL Flush Sy	ringe PRN [	DO NOT ADMINISTER H	IEPARIN TO THIS PATIENT	
				·				
Physic *Sianati	cian's Signature ure Must Be Clear and	Legible				Time	Date	
-	nature (If Required	•				Time	Date	
*Signati	ure Must Be Clear and	) Legible				i iiii©	Date	



STAT REFERRA
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## **RITUXAN (RITUXIMAB)**

		FORMATION		First Name:			MI DOB:_	
HT:		in WT: kg Sex:( ) Male (	) Female	Allergies: ( ) NKD/	Α,			
		me						
		ENT OF MEDICAL NECESSITY Inosis: (ICD-10 Code plus Description)	<u>′</u>					
Does the lf No, d	ne pat loes p	ient have venous access? O Yes ONo atient need venous access? OYes O No IPTION ORDERS	If Yes,	what type? hospital will make ar				
If yes,	wha	nt have venous access?  YE t type: MEDIPORT IPORTS/IV ACCESS WILL BE ACCESSE	PIV	PICC LINE			AL PROTOCOL	
SELEC	Т	Drug		Dose	Route	)	Frequency	Duration
		RITUXAN (RITUXIMAB) (LO	ADING	mg	IV	Over 5	hours on Day 1 and over 4.5 hours on day 15	12 month
PREME	-ne				LABS			
SELECT BELOW		MEDICATION	DOSE	ROUTE	SELECT BELOW	LAB REQUE	STED WHEN	FREQUENCY
	NO	NE	NA	NA		NONE	NA	NA
	BEI	NADRYL				ВМР	( ) PRIOR ( ) POST	
	AC	ETAMINOPHEN				CMP	( ) PRIOR ( ) POST	
	OX	YGEN				BUN/CREATININ	E ()PRIOR ()POST	
	Oth	er:				CRP:	( ) PRIOR ( ) POST	
	Oth	er:				ESR:	( ) PRIOR ( ) POST	
	Oth	er:				Other:	( ) PRIOR ( ) POST	
NOTE	S:			<u> </u>				
FLUSH	IES:	10 mL NS Flush Syringe PRN	Heparin 500	units/5 mL Flush S	Syringe PRN	DO NOT ADM	MINISTER HEPARIN TO THIS PATIENT	
		s Signature lust Be Clear and Legible				Time	e Date	
						Time	e Date	
signal	ure M	lust Be Clear and Legible						

#### IV/IM ANTIBIOTIC ORDER FORM

	in WT:												_
													_
	ne												
기#: ARY DIAGN	NOSIS:			ax ID#:_		SECONDA	RY DIAGNOSIS	Fax #: 6:					-
patient hav	ve venous access?	YES N	NO If "YES", wh	at type	? MED	IPORT PIV	PICC LINE	MID LINE OTHE	R:				
	UCTIONS MUST B MEDIPORTS/IV ACC		•		•	AFTER LAST DOS		FORM LINE CARE	PER HO	SPITAL P	ROTOCOL	JNTIL LINE I	S REMOVE
•	PITAL PHARMACY \							AY INTERVENE PE	R HOSP	TAL PRO	TOCOL FO	R PATIENT S	AFETY
				REI	PEAT							REPEAT	
LECT	DRUG	DOSE	ROUTE	EV	ERY	DURATION	SELECT	DRUG Merrem	D	DSE	ROUTE	EVERY	DURA
	Vancomycin	500 mg	IV					(Meropenem)	500 m	g	( ) IV		
	Vancomycin	750 mg	IV					Merrem (Meropenem)	1000 r	ng	( ) IV		
	Vanaamusia	1000 mg	IV					Gentamicin (Garamycin)			( ) IV		
	Vancomycin	1000 Hig	IV					Levaquin					
	Vancomycin	1500 mg	IV					(Levofloxacin) Levaquin	250 m	g	IV		
	Vancomycin	2000 mg	IV					(Levofloxacin)	500 m	g	IV		
	Rocephin (Ceftriaxone)	250 mg	( ) IV ( ) IM					Levaquin (Levofloxacin)	500 m	n	IV		
	Rocephin							Levaquin		<u> </u>			
	(Ceftriaxone) Rocephin	500 mg	()IV()IM					(Levofloxacin) Dalvance	750 m	g	IV		
	(Ceftriaxone)	750 mg	() IV () IM					(Dalbavancin)	1500 r	0	IV	NA	X 1 Dose
	Rocephin (Ceftriaxone)								1000 Day 1	_			
	(=======							Dalvance	500m				
	Rocephin	1000 mg	( ) IV ( ) IM					(Dalbavancin) Orbactiv	8		IV		
	(Ceftriaxone)	2000 mg	() IV () IM					(Oritavancin)	1200 r	ng	IV		
	Invanz (Ertapenem)	500 mg	( ) IV ( ) IM										
	Învanz												
	(Ertapenem) 1000 mg		g   ()IV ()IM			1				<u>_</u>			
SELEC	T LAB REQU	IESTED	WHEN		SELECT	LAB RE	QUESTED	WHEN		Note	es:		
	NONE		NA			СК		PRIOR ( ) POS	ST()				
	ВМР		PRIOR ( ) POST	)		UA		PRIOR() POS	ST()				
	СМР		PRIOR ( ) POST	)		Other:		PRIOR ( ) POS	ST()				
	BUN/CREATIN	NINE	PRIOR ( ) POST	.)		Other:		PRIOR() POS	ST()				
	CRP		PRIOR() POST	)		Other:		PRIOR() POS	ST()				
	ESR		PRIOR ( ) POST			Other:		PRIOR() POS					
	ALT		PRIOR ( )			Other:		. (7.5					
	VANCO TROU	JGH	FRIOR ( )			Other:							
						Other:							
B	GENT TROUGH					Oulet.	<b>-</b> .						
Physic	ian's Signature						Time		D	ate			