Outpatient Infusion Center
Phone: 269-278-4001
Fax: 877-249-1191

☐ **STAT REFERRAL**

BLOOD PRODUCT TRANSFUSION ORDER FORM

PATIENT INFORMATION

Last Name: ____________________ First Name: ____________________ MI_______ DOB:_______________

HT: __________ in WT: ________ kg Sex :( ) Male ( ) Female Allergies: ( ) NKDA, ____

____

Physician Name____________________ Contact Name ____________________ Contact Phone # ____________________

NPI #:____________________ Tax ID#:____________________ Fax #: ____________________

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD 10 CODE + DESCRIPTION) Secondary Diagnosis: (ICD 10 CODE + DESCRIPTION)

____________________________________ ____________________________________

PERTINENT MEDICAL HISTORY

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

1) Is the patient incontinent? O Yes O No 2) Is the patient ambulatory? O Yes O 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.

Outpatient Infusion Center
Phone: 269-278-4001
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☐ **STAT REFERRAL**

ENTYVIO (VEDOLIZUMAB) ORDER FORM

PATIENT INFORMATION

Last Name: ______________________________ First Name: ____________________________ MI_______ DOB:______________

HT: _________ in WT: ________ kg Sex :( ) Male ( ) Female Allergies: ( ) NKDA, ____

____

Physician Name___________________________________ Contact Name ________________________ Contact Phone # _______________________

NPI #:___________________________________ Tax ID#:_________________________________ Fax #: _________________________________

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: ICD-10 Code plus Description:____

PERTINENT MEDICAL HISTORY **1)** TB test performed? O Yes O No Date:______________________ Results,___________________________________

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

4) Patient previously treated with Entyvio? O Yes O No Date: ____________________ 5) Hep-B antigen surface antibody test? O Yes O 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

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____

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**

GENERAL IV ORDER FORM

PATIENT INFORMATION

Last Name: ______________________ First Name: ______________________ MI_______ DOB:_______________

HT: _________ in WT: _______ kg Sex :( ) Male ( ) Female Allergies: ( ) NKDA, ______________________________

____

Physician Name______________________ Contact Name ______________________ Contact Phone # ______________________

NPI #:______________________ Tax ID#:______________________ Fax #: ______________________

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD 10 CODE + DESCRIPTION) Secondary Diagnosis: (ICD 10 CODE + DESCRIPTION)

______________________________ ______________________________

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

PRESCRIPTION ORDERS

a) ALL MEDIPORTS / IV ACCESSES WILL BE FLUSHED WITH HEPARIN OR SALINE PER HOSPITAL 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**

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____
____
____
____

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**

HYDRATION ORDER FORM

PATIENT INFORMATION

Last Name: ______________________________ First Name: ______________________________ MI_______ DOB:______________

HT: _________ in WT: ________ kg Sex :( ) Male ( ) Female Allergies: ( ) NKDA, ____

____

Physician Name______________________________ Contact Name ____________________ Contact Phone # ____________________

NPI #:______________________________ Tax ID#:______________________________ Fax #: ______________________________

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD 10 CODE) ____ Date of Diagnosis: ______________

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

____
____
____
____
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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**

INTRAVENOUS IMMUNO GLOBULIN ORDER FORM

PATIENT INFORMATION

Last Name: ____________________ First Name: ____________________ MI______ DOB:____________

HT: ________ in WT: _______ kg Sex :( ) Male ( ) Female Allergies: ( ) NKDA, ______________________________

____

Physician Name____________________ Contact Name ________________ Contact Phone # ______________

NPI #:____________________ Tax ID#:____________________ Fax #: ____________________

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: ICD 10 + Description:______________________________ Date of Diagnosis:____________

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 :____

DUE TO LIMITED MEDICATION AVAILABILITY SUSBTITUTION MAY APPLY PER HOSPITAL PROTOCOL

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

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____

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____

____

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 Legibl*

Fax completed form to the Outpatient Infusion Center at 1 (877) 249-1191.
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Fax: 877-249-1191

☐ **STAT REFERRAL**

PROLIA (DENOSUMAB) ORDER FORM

PATIENT INFORMATION

Last Name: ______________________ First Name: ______________________ MI_______ DOB:______________

HT: _________ in WT: _______ kg Sex :( ) Male ( ) Female Allergies: ( ) NKDA, ______________________________

____

Physician Name______________________ Contact Name ______________________ Contact Phone # ______________________

NPI #:______________________ Tax ID#:______________________ Fax #: ______________________

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD-10 CODE + DESCRIPTION)

____ Date of Diagnosis: ______________________

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
- BONE DENSITY/DEXA SCAN WITHIN 2 YEARS OF THE APPOINTMENT– OTHERWISE ONE MUST BE PERFORMED PRIOR TO APPOINTMENT
- 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*

Fax completed form to the Outpatient Infusion Center at 1 (877) 249-1191.
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Fax: 877-249-1191

☐ **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 Allergies: ( ) NKDA, ____

____

Physician Name______________________________ Contact Name ____________________ Contact Phone # ____________________

NPI #:______________________________ Tax ID#:____________________________ Fax #: ______________________________

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD-10 CODE + DESCRIPTION)

____ Date of Diagnosis: ____________________

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**
- **BONE DENSITY/DEXA SCAN WITHIN 2 YEARS OF THE APPOINTMENT– OTHERWISE ONE MUST BE PERFORMED PRIOR TO APPOINTMENT**
- **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.
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Fax: 877-249-1191

☐ **STAT REFERRAL**

REMICADE (INFLIXIMAB) ORDER FORM

PATIENT INFORMATION

Last Name: ______________________ First Name: ______________________ MI_______ DOB:______________

HT: __________ in WT: ________ kg Sex :( ) Male ( ) Female Allergies: ( ) NKDA, ______________________________

____

Physician Name_____________________ Contact Name _________________ Contact Phone # _________________

NPI #:_____________________ Tax ID#:_____________________ Fax #: _____________________

STATEMENT OF MEDICAL NECESSITY ICD-10 Code plus Description

____

PERTINENT MEDICAL HISTORY 1) TB test performed? O Yes O No Results,___________________________

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

4) Patient previously treated with Remicade? O Yes O No Date: ______________ 5) Hep-B antigen surface antibody test? O Yes O 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*

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☐ **STAT REFERRAL**

BONE MARROW STIMULATING AGENTS

PATIENT INFORMATION

Last Name: ____ First Name: ____ MI_______ DOB:______________

HT: _________ in WT: _______ kg Sex :( ) Male ( ) Female Allergies: ( ) NKDA, ____

____

Physician Name____ Contact Name ___________________________ Contact Phone # ___________________________

NPI #:____ Tax ID#:_____________________________________ Fax #: _____________________________________

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

____

Date of Diagnosis: ___________________

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

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Outpatient Infusion Center
Phone: 269-278-4001
Fax: 877-249-1191

☐ **STAT REFERRAL**

TYSABRI (NATALIZUMAB)

PATIENT INFORMATION

Last Name: ______________________ First Name: ______________________ MI________ DOB:______________

HT: __________ in WT: ________ kg Sex :( ) Male ( ) Female Allergies: ( ) NKDA, ______________________________

____

Physician Name______________________ Contact Name ______________________ Contact Phone # ______________________

NPI #:______________________ Tax ID#:______________________ Fax #: ______________________

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD-10 Code plus Description)

____

Date of Diagnosis: ____________________

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

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.
PLEASE include copies of: H+P, OFFICE NOTES, LABS, ACTIVE MEDICATION PROFILE, and CURRENT INSURANCE INFORMATION in order for your referral to be processed.

Outpatient Infusion Center
Phone: 269-278-4001
Fax: 877-249-1191

☐ **STAT REFERRAL**

XOLAIR (OMALIZUMAB)

PATIENT INFORMATION

Last Name: ______________________ First Name: ______________________ MI_______ DOB:_______________

HT: __________ in WT: ________ kg Sex :( ) Male ( ) Female Allergies: ( ) NKDA, ______________________________

____

Physician Name______________________ Contact Name ______________________ Contact Phone # ______________________

NPI #:______________________ Tax ID#:______________________ Fax #: ______________________

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD-10 Code plus Description)

____

Date of Diagnosis: ____________________

PRESCRIPTION ORDERS

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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☐ **STAT REFERRAL**

SIMPONI ARIA (GOLIMUMAB)

PATIENT INFORMATION

Last Name: ______________________ First Name: ______________________ MI______ DOB:____________

HT: ________ in WT: _______ kg Sex :( ) Male ( ) Female Allergies: ( ) NKDA, ______________________________

____

Physician Name______________________ Contact Name ______________ Contact Phone # ______________

NPI #:______________________ Tax ID#:____________________ Fax #: ____________________

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD-10 Code plus Description)

____

Date of Diagnosis: ____________________

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

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*

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☐ **STAT REFERRAL**

ORENCIA (ABATACEPT)

PATIENT INFORMATION

Last Name: ______________________________ First Name: ______________________________ MI_______ DOB:______________

HT: _________ in WT: ________ kg Sex :( ) Male ( ) Female Allergies: ( ) NKDA, ______________________________

____

Physician Name______________________________ Contact Name ____________________ Contact Phone # ____________________

NPI #:______________________________ Tax ID#:______________________________ Fax #: ______________________________

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD-10 Code plus Description)

____

Date of Diagnosis: ____________________

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

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*

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☐ **STAT REFERRAL**

VENOFER (IRON SUCROSE)

PATIENT INFORMATION

Last Name: ______________________________ First Name: ______________________________ MI______ DOB:____________

HT: ________ in WT: _______ kg Sex :( ) Male ( ) Female Allergies: ( ) NKDA, ____

____

Physician Name______________________________ Contact Name ____________________ Contact Phone # ____________________

NPI #:______________________________ Tax ID#:____________________________ Fax #: ____________________________

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD-10 Code plus Description)

____

Date of Diagnosis: ________________

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

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*

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Fax: 877-249-1191

☐ **STAT REFERRAL**

OCREVUS (OCRELIZUMAB)

PATIENT INFORMATION

Last Name: ______________________ First Name: ______________________ MI_______ DOB:______________

HT: __________ in WT: ________ kg Sex :( ) Male ( ) Female Allergies: ( ) NKDA, ______________________

____

Physician Name______________________ Contact Name ______________________ Contact Phone # ______________________

NPI #:______________________ Tax ID#:______________________ Fax #: ______________________

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD-10 Code plus Description)

____

Date of Diagnosis: ____________________

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

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:____

____

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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*

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Fax: 877-249-1191

☐ **STAT REFERRAL**

RITUXAN (RITUXIMAB)

PATIENT INFORMATION

Last Name: ______________________ First Name: ______________________ MI_______ DOB:______________

HT: _________ in WT: ________ kg Sex :( ) Male ( ) Female Allergies: ( ) NKDA, ______________________________

____

Physician Name______________________ Contact Name ______________________ Contact Phone # ______________________

NPI #:______________________ Tax ID#:______________________ Fax #: ______________________

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD-10 Code plus Description)

____

Date of Diagnosis: ____________________

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

SELECT	Drug	Dose	Route	Frequency	Duration
	RITUXAN (RITUXIMAB) (LOADING DOSES)	______mg	IV	Over 5 hours on Day 1 and over 4.5 hours on day 15	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*

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Fax: 877-249-1191

☐ **STAT REFERRAL**

IV/IM ANTIBIOTIC ORDER FORM

PATIENT INFORMATION

Last Name: ______________________ First Name: ______________________ MI_______ DOB:______________

HT: _________ in WT: _______ kg Sex :( ) Male ( ) Female Allergies: ( ) NKDA, ______________________________

____

Physician Name______________________ Contact Name ______________________ Contact Phone # ______________________

NPI #:______________________ Tax ID#:______________________ Fax #: ______________________

PRIMARY DIAGNOSIS:______________________ **SECONDARY DIAGNOSIS**:______________________

Does patient have venous access? YES NO If "YES", what type? MEDIPORT PIV PICC LINE MID LINE OTHER:______________________

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

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

SELECT	DRUG	DOSE	ROUTE	REPEAT EVERY	DURATION
	Vancomycin	500 mg	IV		
	Vancomycin	750 mg	IV		
	Vancomycin	1000 mg	IV		
	Vancomycin	1500 mg	IV		
	Vancomycin	2000 mg	IV		
	Rocephin (Ceftriaxone)	250 mg	( ) IV ( ) IM		
	Rocephin (Ceftriaxone)	500 mg	( ) IV ( ) IM		
	Rocephin (Ceftriaxone)	750 mg	( ) IV ( ) IM		
	Rocephin (Ceftriaxone)	1000 mg	( ) IV ( ) IM		
	Rocephin (Ceftriaxone)	2000 mg	( ) IV ( ) IM		
	Invanz (Ertapenem)	500 mg	( ) IV ( ) IM		
	Invanz (Ertapenem)	1000 mg	( ) IV ( ) IM		

SELECT	DRUG	DOSE	ROUTE	REPEAT EVERY	DURATION
	Merrem (Meropenem)	500 mg	( ) IV		
	Merrem (Meropenem)	1000 mg	( ) IV		
	Gentamicin (Garamycin)		( ) IV		
	Levaquin (Levofloxacin)	250 mg	IV		
	Levaquin (Levofloxacin)	500 mg	IV		
	Levaquin (Levofloxacin)	500 mg	IV		
	Levaquin (Levofloxacin)	750 mg	IV		
	Dalvance (Dalbavancin)	1500 mg	IV	NA	X 1 Dose
	Dalvance (Dalbavancin)	1000 mg Day 1, 500mg Day 8	IV		
	Orbactiv (Oritavancin)	1200 mg	IV		

SELECT	LAB REQUESTED	WHEN
	NONE	NA
	BMP	PRIOR ( ) POST ( )
	CMP	PRIOR ( ) POST ( )
	BUN/CREATININE	PRIOR ( ) POST ( )
	CRP	PRIOR ( ) POST ( )
	ESR	PRIOR ( ) POST ( )
	ALT	PRIOR ( )
	VANCO TROUGH	
	GENT TROUGH	

SELECT	LAB REQUESTED	WHEN
	CK	PRIOR ( ) POST ( )
	UA	PRIOR ( ) POST ( )
	Other:	PRIOR ( ) POST ( )
	Other:	PRIOR ( ) POST ( )
	Other:	PRIOR ( ) POST ( )
	Other:	PRIOR ( ) POST ( )
	Other:	
	Other:	
	Other:	

Notes:______________________

Physician's Signature ______________________**Time**______________ **Date**______________
**Signature must be clear and legible with the time and date of signature for order to be processed*

Co-Signature (If Required)______________________ **Time**______________ **Date**______________
**Signature must be clear and legible with the time and date of signature for order to be processed*

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