

SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES
ACTH STIMULATION TEST ORDER FORM



STAT REFERRAL

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 POLICY PRN

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

LABS

NOTES/INSTRUCTIONS/OTHER

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

- Vital signs will be measured prior to beginning test AND at completion of test, and with any clinical changes that occur during the test. Notify physician if SBP > 180, DBP > 110, or pulse > 120
- Flush line with 10 mL 0.9% NS then DC IV access.

Physician's Signature _____ Time _____ Date _____

*Signature Must Be Clear and Legible

Cosignature (If Required) _____ Time _____ Date _____

*Signature Must Be Clear and Legible

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 580-531-4779.

SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES
ANTIBIOTICS ORDER FORM

☐ **STAT REFERRAL**

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 ☐ OTHER: _____

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

- a) ALL MEDIPOINTS/IV ACCESSES MAY BE FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL POLICY
b) 500 mL BAG OF 0.9% NS MAY BE HUNG AT KVO RATE
c) HOSPITAL PHARMACY WILL FOLLOW AND ADJUST DOSING FOR VANCOMYCIN, GENTAMICIN, AND MAY INTERVENE PER HOSPITAL POLICY FOR PATIENT SAFETY

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

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

OTHER MEDICATION (not listed): _____

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

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

NOTES:

Physician's Signature _____ Time _____ Date _____

*Signature must be clear and legible

Co-Signature (If Required) _____ Time _____ Date _____

*Signature must be clear and legible

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 580-531-4779.

SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES
ASTHMA AGENTS

☐ **STAT REFERRAL**

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

- a) WEIGHT BASED DOSING WILL REMAIN FOR DURATION OF ORDER UNLESS WEIGHT CHANGES +/- BY 10 %
 b) Pretreatment Serum IgE (Xolair) _____

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

PREMEDS

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

LABS

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

NOTES/SPECIAL INSTRUCTIONS:

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

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

SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES
BLOOD PRODUCT TRANSFUSION ORDER FORM



STAT REFERRAL

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? ☐ Yes ☐ No 2) Is the patient ambulatory? ☐ Yes ☐ No

2) Has the patient taken Darzalex (daratumumab) within the last 6 months? ☐ Yes ☐ No

3) Has type and cross been drawn? ☐ Yes ☐ No If yes, date and time _____. If no, patient to go to hospital lab on _____ date/time OR _____ to be drawn at Infusion Center on arrival.

NOTES: _____

PRESCRIPTION ORDERS:

- a) ALL MEDIPORTS / IV ACCESS WILL BE ACCESSED AND FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL POLICY PRN
- b) 500 mL BAG OF 0.9% NS MAY BE HUNG AT KVO RATE
- c) TUBING WILL BE FLUSHED WITH 0.9% NS UNTIL TUBING IS PINK TINGED OR CLEAR
- d) H+H MUST BE COMPLETED WITHIN ONE WEEK OF ALL BLOOD PRODUCT TRANSFUSIONS

TYPE, CROSSMATCH, AND TRANSFUSE:

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

LABS

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

PREMEDS

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

NOTES/INSTRUCTIONS/COMMENTS

DIETARY RESTRICTIONS (If none, please indicate): _____

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

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

SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES
BONE MARROW STIMULATING AGENTS ORDER FORM

☐ **STAT REFERRAL**

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

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

Hold erythropoietin injections if Hemoglobin is \geq to 12 g/dL

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

NOTES/SPECIAL INSTRUCTIONS:

Physician's Signature _____ Time _____ Date _____

**Signature Must Be Clear and Legible*

Cosignature (If Required) _____ Time _____ Date _____

**Signature Must Be Clear and Legible*

SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES
GASTROENTEROLOGY ORDER FORM



STAT REFERRAL

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

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

1) TB test performed? ☐ Yes ☐ No Date: _____ Results: _____

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

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

5) Hep-B antigen surface antibody test? ☐ Yes ☐ No Date: _____

PRESCRIPTION ORDERS:

- a) ALL MEDIPOINTS / IV ACCESSES WILL BE FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL POLICY
- b) 500 mL BAG OF 0.9% NS MAY BE HUNG AT KVO RATE
- c) ALL PRODUCTS WILL BE PREPARED AND ADMINISTERED FOLLOWING HOSPITAL POLICY

SELECT	DOSING OPTIONS	DOSE	ROUTE	FREQUENCY (POPULATE BELOW)	DURATION
<input type="checkbox"/>	ENTYVIO (LOADING DOSES)	300 mg	IV	0, 2, 6 WEEKS, THEN ONCE EVERY 8 WEEKS	
<input type="checkbox"/>	ENTYVIO (MAINTENANCE DOSE)	300 mg	IV	ONCE EVERY 8 WEEKS	
<input type="checkbox"/>	RENFLEXIS (LOADING DOSES)	_____ mg / kg	IV	0, 2, 6 WEEKS, THEN ONCE EVERY _____ WEEKS	
<input type="checkbox"/>	RENFLEXIS (MAINTENANCE DOSES)	_____ mg / kg	IV	ONCE EVERY _____ WEEKS	
<input type="checkbox"/>	OTHER:	_____ mg / kg	IV	ONCE EVERY _____ WEEKS	

PREMEDS

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

LABS

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

NOTES/INSTRUCTIONS/COMMENTS

Physician's Signature _____ Time _____ Date _____

*Signature Must Be Clear and Legible

Cosignature (If Required) _____ Time _____ Date _____

*Signature Must Be Clear and Legible

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 580-531-4779.

SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES
GENERAL IV ORDER FORM

☐ **STAT REFERRAL**

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 POLICY PRN

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

PLEASE SELECT FROM BELOW:

_____ Perform port flush every _____ weeks per hospital policy.

_____ Perform IV site care per hospital policy.

NOTE: For patients with central venous access, please select: ☐ D/C AFTER LAST DOSE

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

LABS			NOTES/INSTRUCTIONS/OTHER
SELECT	LAB REQUESTED	FREQUENCY	
<input type="checkbox"/>	NONE	NA	
<input type="checkbox"/>	CBC w/ Diff		
<input type="checkbox"/>	BMP		
<input type="checkbox"/>	CMP		
<input type="checkbox"/>	BUN/CREATININE		
<input type="checkbox"/>	ESR		
<input type="checkbox"/>	CRP		
<input type="checkbox"/>	CPK		
<input type="checkbox"/>	Other:		
<input type="checkbox"/>	Other:		

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

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

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 580-531-4779.

SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES
HEADACHE ORDER FORM

☐ **STAT REFERRAL**

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: _____

PERTINENT MEDICAL HISTORY

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

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

PRESCRIPTION ORDERS

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

PREMEDS

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

LABS

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

Physician's Signature _____ Time _____ Date _____

**Signature Must Be Clear and Legible*

Cosignature (If Required) _____ Time _____ Date _____

**Signature Must Be Clear and Legible*

SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES
HYDRATION ORDER FORM

☐ **STAT REFERRAL**

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: _____

PERTINENT MEDICAL HISTORY

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

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

PRESCRIPTION ORDERS FOR HYDRATION

Select the fluid requested AND the corresponding rate below

1.) ☐ NORMAL SALINE

2.) ☐ LACTATED RINGERS

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

RATE

RATE

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

LABS:

NOTES/INSTRUCTIONS/COMMENTS

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

Physician's Signature _____ Time _____ Date _____

*Signature Must Be Clear and Legible

Cosignature (If Required) _____ Time _____ Date _____

*Signature Must Be Clear and Legible

**SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES
 INTRAVENOUS IMMUNE GLOBULIN ORDER FORM**

☐ **STAT REFERRAL**

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: _____

PERTINENT MEDICAL HISTORY

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

PRESCRIPTION ORDERS:

- a) ALL MEDIPOINTS / IV ACCESSES WILL BE FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL POLICY
- b) ALL PRODUCTS WILL BE PREPARED AND ADMINISTERED FOLLOWING HOSPITAL POLICY
- c) 500 mL BAG OF 0.9% NS MAY BE HUNG AT KVO RATE

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

PREMEDS

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

LABS

SELECT	LAB REQUESTED	WHEN	FREQUENCY
<input type="checkbox"/>	BMP	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	
<input type="checkbox"/>	CMP	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	
<input type="checkbox"/>	BUN/CREATININE	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	
<input type="checkbox"/>	Other:	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	
<input type="checkbox"/>	Other:	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	

NOTES/SPECIAL INSTRUCTIONS

Physician's Signature _____ Time _____ Date _____

**Signature Must Be Clear and Legible*

Cosignature (If Required) _____ Time _____ Date _____

**Signature Must Be Clear and Legible*

SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES
IRON PRODUCTS ORDER FORM

☐ **STAT REFERRAL**

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: _____

PERTINENT MEDICAL HISTORY

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

PRESCRIPTION ORDERS

- a) ALL MEDIPOINTS/IV ACCESS WILL BE ACCESSED AND FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL POLICY
- b) ALL PRODUCTS WILL BE PREPARED AND ADMINISTERED FOLLOWING HOSPITAL POLICY
- c) SUPPORTING LABWORK AND DOCUMENTATION OF ORAL IRON TREATMENT MAY BE REQUIRED BASED ON INDIVIDUAL PAYOR GUIDELINES
- d) 500 mL BAG OF 0.9% NS MAY BE HUNG AT KVO RATE

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

PREMEDS

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

LABS

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

NOTES: _____

Physician's Signature _____ Time _____ Date _____

*Signature Must Be Clear and Legible

Cosignature (If Required) _____ Time _____ Date _____

*Signature Must Be Clear and Legible

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 580-531-4779.

SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES
LEQEMBI ORDER FORM

☐ **STAT REFERRAL**

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 #: _____

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

- a) ALL MEDIPORTS / IV ACCESSES WILL BE FLUSHED WITH HEPARIN OR SALINE PER HOSPITAL PROTOCOL PRN
b) 500 mL BAG OF 0.9% NS MAY BE HUNG AT KVO RATE

PLEASE SELECT FROM BELOW:

- _____ Perform port flush every _____ weeks per hospital policy.
_____ Perform IV site care per hospital protocol.
_____ Activase 2mg IVP per hospital protocol.

DUAL DIAGNOSIS IS REQUIRED – SELECT ONE OPTION OF BOTH CONDITIONS THAT APPLY FROM BELOW:

- ☐ G30.0 Alzheimer's Disease, Early Onset ☐ F02.80 Dementia without behavioral disturbance
☐ G30.1 Alzheimer's Disease, Late Onset ☐ F02.81 Dementia with behavioral disturbance
☐ G30.8 Other Alzheimer's disease
☐ G30.9 Alzheimer's disease, unspecified
☐ G31.84 Mild Cognitive Impairment, So Stated
☐ Other: _____ (ICD 10 + Description)

← G30.X codes require
secondary F02.8X code →

Prescriber must indicate the following requirements have been met (please provide documentation):

- ☐ Beta Amyloid Pathology Confirmed Via
☐ Amyloid PET Scan Date: _____ OR ☐ CSF Analysis Date: _____ Result: _____
☐ Cognitive Assessment Used: _____ Date: _____ Result: _____
☐ ApoE ε4 Genetic Test Date: _____ Result: ☐ Homozygote ☐ Heterozygote ☐ Noncarrier

PRESCRIPTION ORDERS

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

Pre-Infusion:

- ☒ Confirm baseline MRI results prior to initiation of treatment.
☒ Confirm MRI completed and reviewed by prescriber prior to the 5th, 7th, and 14th treatment.
☒ Measure and record weight prior to each treatment to determine dose.
☒ Hold infusion and notify provider if patient reports:
- Headache.
 - Dizziness.
 - Nausea.
 - Vision changes.
 - New or worsening confusion.

Post-Infusion:

- ☒ Educate patient/caregiver to report headache, dizziness, nausea, vision changes, or new/worsening confusion.

Physician's Signature _____ Time _____ Date _____

*Signature Must Be Clear and Legible

Cosignature (If Required) _____ Time _____ Date _____

*Signature Must Be Clear and Legible

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 580-531-4779.

SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES
LEQVIO ORDER FORM

☐ **STAT REFERRAL**

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

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

LABS

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

SUPPORTING DOCUMENTATION FOR PATIENTS RECEIVING LEQVIO

- SUPPORTING CLINICAL NOTES TO INCLUDE ANY PAST TRIED AND/OR FAILED THERAPIES, INTOLERANCE, BENEFITS, OR CONTRAINDICATIONS TO CONVENTIONAL THERAPY
- HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HEFH) - DOES THE PATIENT HAVE A UNTREATED LDL \geq 190MG/DL (\geq 155MG/DL IF <16 YEARS OF AGE)? ☐ YES ☐ NO
- PLEASE MARK ANY OF THE FOLLOWING CRITERIA THE HEFH PATIENT MEETS:
 - ☐ PRESENCE OF TENDON XANTHOMA(S) IN THE PATIENT OR 1ST/2ND DEGREE RELATIVE
 - ☐ FAMILY HISTORY OF MI AT <60 YEARS OLD IN 1ST DEGREE RELATIVE OR <50 YEARS OLD IN 2ND DEGREE RELATIVE
 - ☐ FAMILY HISTORY OF TOTAL CHOLESTEROL > THAN 290MG/DL IN A 1ST/2ND DEGREE RELATIVE
 - ☐ ARCUS CORNEALIS BEFORE AGE 45
- ASCVD - DOES THE PATIENT'S LDL REMAIN \geq 100MG/DL DESPITE TREATMENT WITH A HIGH-INTENSITY STATIN? ☐ YES ☐ NO
- HAS THE PATIENT TRIED AND FAILED PCSK9 INHIBITOR AFTER 12 WEEKS OF USE? ☐ YES ☐ NO
- HAS THE PATIENT TRIED AND FAILED A HIGH INTENSITY STATIN FOR \geq 8 CONTINUOUS WEEKS? ☐ YES ☐ NO
- INDICATE ANY CONDITIONS THE PATIENT HAS:
 - ☐ ACUTE CORONARY SYNDROME ☐ HISTORY OF MYOCARDIAL INFARCTION
 - ☐ CORONARY OR OTHER ARTERIAL REVASCULARIZATION ☐ TRANSIENT ISCHEMIC ATTACK
 - ☐ PERIPHERAL ARTERIAL DISEASE PRESUMED TO BE OF ATHEROSCLEROTIC ORIGIN ☐ STROKE
- INCLUDE LABS AND/OR TEST RESULTS TO SUPPORT DIAGNOSIS
 - ☐ LDL-C (Required)
 - ☐ MUTATION IN LDL, APOB, OR PCSK9 GENE (If Applicable)
- OTHER MEDICAL NECESSITY: _____

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

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

SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES
NEUROLOGY ORDER FORM

☐ **STAT REFERRAL**

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: _____

PERTINENT MEDICAL HISTORY

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 SALINE OR HEPARIN PER HOSPITAL POLICY
- b) ALL PRODUCTS WILL BE PREPARED AND ADMINISTERED FOLLOWING HOSPITAL POLICY
- c) 500 mL BAG OF 0.9% NS MAY BE HUNG AT KVO RATE

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

PREMEDS

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

LABS

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

NOTES/INSTRUCTIONS/COMMENTS:

Physician's Signature _____ Time _____ Date _____

*Signature Must Be Clear and Legible

Cosignature (If Required) _____ Time _____ Date _____

*Signature Must Be Clear and Legible

SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES
OSTEOPOROSIS ORDER FORM

☐ **STAT REFERRAL**

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: _____

PERTINENT MEDICAL HISTORY

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

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

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

PRESCRIPTION ORDERS

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY	DURATION
<input type="checkbox"/>	RECLAST (ZOLEDRONIC ACID) ADMINISTER OVER NO LESS THAN 15 MINUTES BUN, CREAT, AND CALCIUM LEVEL WITHIN 90 DAYS OF APPOINTMENT HOLD IF CALCIUM LEVELS < <u>8.5mg/dL</u> or IONIZED CALCIUM LEVEL < <u>4.5mg/dL</u> or IF CRCL < <u>35 ML/MIN</u>	5 mg	IV	ONCE EVERY 12 MONTHS	1 Year
<input type="checkbox"/>	PROLIA (DENOSUMAB) BUN, CREAT, CALCIUM LEVEL WITHIN 90 DAYS OF THE APPOINTMENT HOLD IF CALCIUM LEVELS < <u>8.5mg/dL</u> or IONIZED CALCIUM LEVEL < <u>4.5mg/dL</u> or IF CRCL < <u>30 ML/MIN</u>	60 mg	SC	ONCE EVERY 6 MONTHS	1 Year
<input type="checkbox"/>	EVENITY BUN, CREAT, CALCIUM LEVEL WITHIN 90 DAYS OF THE APPOINTMENT HOLD IF CALCIUM LEVELS < <u>8.5 mg/dL</u> or IONIZED CALCIUM LEVEL < <u>4.5 mg/dL</u> or IF CRCL < <u>30 ML/MIN</u>	210 mg	SC	ONCE EVERY MONTH x 12	1 Year

SUPPORTING DOCUMENTATION FOR PATIENTS RECEIVING RECLAST, PROLIA, OR EVINITY:

- 1) OSTEOPOROSIS:**
 - CALCIUM, BUN, AND SERUM CREATININE MUST BE CHECKED WITHIN THE LAST 90 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, Bisphosphonates)
- 2) MEN AT HIGH RISK OF FRACTURE RECEIVING ANDROGEN DEPRIVATION THERAPY FOR NONMETASTATIC PROSTATE CANCER**
- 3) TREATMENT TO INCREASE BONE MASS IN WOMEN AT HIGH RISK FOR FRACTURE RECEIVING AROMATASE INHIBITOR THERAPY FOR BREAST CANCER**

*OSTEOPENIA IS 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 OF A PREVIOUS FRAGILITY FRACTURE.

*PLEASE SUBMIT DOCUMENTATION OF ANY TRIED AND FAILED ORAL / INJECTIBLE MEDICATIONS ALONG WITH THE SUPPORTING DOCUMENTATION OF THE PATIENT RESPONSE / FAILURE TO TREATMENT.

*PROLIA 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, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 580-531-4779.

SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES
RHEUMATOLOGY ORDER FORM

☐ **STAT REFERRAL**

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

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

1) TB test performed? ☐ Yes ☐ No Date: _____ Results: _____

2) Hep-B antigen surface antibody test? ☐ Yes ☐ No Date: _____

3) Patient previously treated with any of the following: (please select) ☐ Remicade ☐ Inflectra ☐ Simponi Aria ☐ Benlysta ☐ Rituxan ☐ Orencia ☐ Actemra ☐ Stelara, Date: _____

PRESCRIPTION ORDERS:

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

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

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

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

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY	DURATION
<input type="checkbox"/>	Actemra	_____ mg/kg	IV	Every _____ Weeks	
<input type="checkbox"/>	Benlysta Loading Dose(s)	10 mg / kg	IV	0, 2, 4 Weeks, Then Once Every 4 Weeks	
<input type="checkbox"/>	Benlysta Maintenance Dose	10 mg / kg	IV	Once Every 4 Weeks	
<input type="checkbox"/>	Krystexxa	8 mg	IV	Once Every 4 Weeks	
<input type="checkbox"/>	Orencia Loading Dose(s)	_____ mg	IV	0, 2, 4 Weeks, Then Once Every 4 Weeks	
<input type="checkbox"/>	Orencia Maintenance Dose(s)	500 mg	IV	Once Every 4 Weeks	
<input type="checkbox"/>	Orencia Maintenance Dose(s)	750 mg	IV	Once Every 4 Weeks	
<input type="checkbox"/>	Orencia Maintenance Dose(s)	1000 mg	IV	Once Every 4 Weeks	
<input type="checkbox"/>	Remicade Loading Dose(s)	_____ mg / kg	IV	0, 2, 6 Weeks, Then Once Every _____ Weeks	
<input type="checkbox"/>	Remicade Maintenance Dose(s)	_____ mg / kg	IV	Once Every _____ Weeks	
<input type="checkbox"/>	Rituxan	_____ mg / kg	IV	Once Every _____ Weeks	
<input type="checkbox"/>	Simponi Aria	_____ mg / kg	IV	Once Every _____ Weeks	
<input type="checkbox"/>	Stelara Loading Dose(s) *SC administration is NOT covered Outpatient	_____ mg	IV	Once	1

PREMEDS

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

LABS

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

Physician's Signature _____ Time _____ Date _____

*Signature Must Be Legible

Cosignature (If Required) _____ Time _____ Date _____

*Signature Must Be Legible

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 580-531-4779.

**SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES
 THERAPEUTIC PHLEBOTOMY ORDER FORM**

☐ **STAT REFERRAL**

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)

PRESCRIPTION ORDERS

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

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

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

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

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

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 580-531-4779.

SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES
VENOFER (IRON SUCROSE) ORDER FORM

☐ **STAT REFERRAL**

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: _____

PERTINENT MEDICAL HISTORY

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

PRESCRIPTION ORDERS

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

MEDICATION	DOSE	ROUTE	FREQUENCY	DURATION
VENOFER		IV	Every _____ days	

PREMEDS

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

LABS

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

NOTES:

Physician's Signature _____ Time _____ Date _____

**Signature Must Be Clear and Legible*

Cosignature (If Required) _____ Time _____ Date _____

**Signature Must Be Clear and Legible*