

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

- a) BIOSIMILAR EQUIVALENT RETACRIT SUBSTITUTION MAY APPLY
- b) BIOSIMILAR EQUIVALENT GRANIX SUBSTITUTION MAY APPLY

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
	Aranesp				
	Neulasta				
	Neupogen (Granix Substitute)				
	Procrit ESRD (<i>Patients on Dialysis</i>)				
	Procrit NON ESRD				
	Retacrit ESRD (<i>Patients on Dialysis</i>)				
	Retacrit NON ESRD				
	Other:				

NOTES: _____

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

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