



MATAGORDA REGIONAL
MEDICAL CENTER

MRMC IV THERAPY SERVICES
PHONE: 979-446-0818
FAX: 1-877-249-1191

PROLIA (DENOSUMAB) ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI _____ DOB: _____
HT: _____ WT: _____ Sex : () Male () Female SSN: _____ Home #: _____ Cell#: _____
Street Address _____ City/State/Zip _____
Allergies: _____

INSURANCE INFORMATION

Primary Insurance Name _____ Policy ID #: _____
Secondary Insurance Name _____ Policy ID #: _____

PHYSICIAN / FACILITY INFORMATION

Physician Name _____ Contact Name _____ Contact Phone # _____
Address: _____ City/State/Zip _____
DEA#: _____ NPI #: _____ State Lic #: _____ Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD-10 CODE) _____
Date of Diagnosis: _____

PRESCRIPTION ORDERS

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

INCLUDE COPIES OF THE FOLLOWING:

- **BUN, CREATININE, and CALCIUM MUST BE CHECKED WITHIN THE LAST 30 DAYS OTHERWISE HOSTPIAL WILL COLLECT LABS PRIOR TO INFUSION.**
- **BONE DENSITY/DEXA SCAN WITHIN THE LAST 2 YEARS – OTHERWISE ONE WILL BE PERFORMED PRIOR TO THE DATE OF SERVICE**
- **OFFICE NOTES SUPPORTING THE DIAGNOSIS OF OSTEOPOROSIS/OSTEOPENIA DATED WITHIN THE LAST 2 YEARS**
- **H+P DATED WITHIN THE LAST 2 YEARS**
- **PRIOR/CURRENT MEDICATIONS USED TO TREAT THE DIAGNOSIS OF OSTEOPOROSIS/OSTEOPENIA MUST BE DOCUMENTED IN PATIENT’S MEDICAL RECORD. Examples: Oral calcium, Vitamin D**

Labs Needed: **BUN, CALCIUM and CREATININE (if previous results not provided within last 30 days)**

Provider’s Signature : _____ Time: _____ Date: _____

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.



MATAGORDA REGIONAL MEDICAL CENTER

MPMC IV THERAPY SERVICES
PHONE: 979-446-0818
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STAT REFERRAL

PHLEBOTOMY ORDER FORM

PATIENT INFORMATION

Last Name: First Name: MI DOB:
HT: WT: Sex: () Male () Female SSN: Home #: Cell#:
Street Address City/State/Zip
Allergies:

INSURANCE INFORMATION

Primary Insurance Name Policy ID #:
Secondary Insurance Name Policy ID #:

PHYSICIAN / FACILITY INFORMATION

Physician Name Contact Name Contact Phone #
Address: City/State/Zip
DEA#: NPI #: State Lic #: Fax #:

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (select appropriate code)
D45 Polycythemia Vera D75.1 Secondary Polycythemia D75.1 Testosterone Replacement Therapy
E83.110 Hereditary Hemochromatosis E83.118 Other Hemochromatosis
Other (Include both ICD-10 Code and Diagnosis) Date of Diagnosis:
Does the patient have any medical contraindications for this procedure?
Does the patient have venous access?
If No, does patient need venous access?

PRESCRIPTION ORDERS

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

DO NOT ADMINISTER HEPARIN TO THIS PATIENT

Table with 6 columns: Therapeutic Phlebotomy, UNITS TO REMOVE, PARAMETERS, HGB LAB VALUE, FREQUENCY, DURATION. Includes checkboxes for Weekly, Monthly, and Other.

LABS

NOTES/INSTRUCTIONS/OTHER

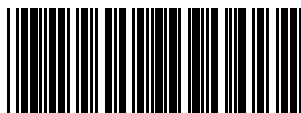
Table with 3 columns: SELECT BELOW, LAB REQUESTED, FREQUENCY. Includes rows for Hgb & Hct, CBC w/ Diff, BMP, CMP, BUN/CREATININE, ESR, CRP, CPK, and Other.

FLUSHES: 10 mL NS Flush Syringe PRN Heparin 500 units/5 mL Flush Syringe PRN NS 50 mL PRN

I have evaluated this patient, I am aware of no contraindications to this procedure, I have explained the reason for this procedure to the patient, and I will be responsible for the patient's follow-up care.

Physician's Signature Time Date

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.



Phlebotomy Order Form

MATAGORDA REGIONAL MEDICAL CENTER

PATIENT LABEL



MATAGORDA REGIONAL
MEDICAL CENTER

MPMC IV THERAPY SERVICES
PHONE: 979-446-0818
FAX: 1-877-249-1191

STAT REFERRAL

BLOOD PRODUCT TRANSFUSION ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI _____ DOB: _____
HT: _____ WT: _____ Sex : () Male () Female SSN: _____ Home #: _____ Cell#: _____
Street Address _____ City/State/Zip _____
Allergies: _____

INSURANCE INFORMATION

Primary Insurance Name _____ Policy ID #: _____
Secondary Insurance Name _____ Policy ID #: _____

PHYSICIAN / FACILITY INFORMATION

Physician Name _____ Contact Name _____ Contact Phone # _____
Address: _____ City/State/Zip _____
DEA#: _____ NPI #: _____ State Lic #: _____ Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD 10 CODE) _____ Secondary Diagnosis: (ICD 10 CODE) _____

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

- a) ALL MEDIPORTS/IV ACCESS WILL BE ACCESSED AND FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL PROTOCOL PRN
- b) CBC RESULTS MUST BE DRAWN 48 HOURS PRIOR UNLESS MEDICAL NECESSITY CAN BE ESTABLISHED
- c) 250 CC BAG OF NORMAL SALINE WILL BE HUNG WITH EVERY TRANSFUSION
- d) H+H WILL BE COLLECTED PRIOR TO INITIATION OF ALL TRANSFUSIONS

PRESCRIPTION ORDERS

SELECT BELOW	# of UNITS	PRODUCT
		LEUKO REDUCED PRBCs
		LEUKO REDUCED IRRADITED PRBCs
		LEUKO REDUCED PLATELETS
		LEUKO REDUCED IRRADIATED PLATELETS
		PLASMA

LABS

SELECT BELOW	LAB REQUESTED	WHEN
	BMP	() PRIOR () POST
	CMP	() PRIOR () POST
	CBC w/ DIFF	() PRIOR () POST
	H+H:	() PRIOR () POST
	Other:	() PRIOR () POST

PREMEDS

SELECT BELOW	MEDICATION	DOSE	ROUTE
	BENADRYL, PRN		
	ACETAMINOPHEN, PRN		
	OXYGEN		
	Other:		
	Other:		

NOTES/INSTRUCTIONS/COMMENTS

FLUSHES: (select all that apply) 10 mL NS Flush Syringe PRN Heparin 500units/5 mL Flush Syringe PRN NS 500 mL PRN

Physician's Signature _____ Time _____ Date _____

<p>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.</p>



MATAGORDA REGIONAL
 MEDICAL CENTER
 MRMCM IV THERAPY SERVICES
 PHONE: 979-446-0818
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ENTYVIO (VEDOLIZUMAB) ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI _____ DOB: _____
 HT: _____ WT: _____ Sex : () Male () Female SSN: _____ Home #: _____ Cell#: _____
 Street Address _____ City/State/Zip _____
 Allergies: _____

INSURANCE INFORMATION

Primary Insurance Name _____ Policy ID #: _____
 Secondary Insurance Name _____ Policy ID #: _____

PHYSICIAN / FACILITY INFORMATION

Physician Name _____ Contact Name _____ Contact Phone # _____
 Address: _____ City/State/Zip _____
 DEA#: _____ NPI #: _____ State Lic #: _____ Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: ICD-10 Code plus Description: _____

PERTINENT MEDICAL HISTORY

- 1) TB test performed? Yes No Results: _____
- 2) Patient diagnosed with Congestive Heart Failure? Yes No
- 3) Liver function test normal? Yes No
- 4) Patient previously treated with Entyvio? Yes No Date: _____
- 5) Hep-B antigen surface antibody test? Yes No Date: _____
- a) ALL MEDIPOINTS / 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 FLITER
- 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: MEDIPOINT PIV PICC LINE OTHER: _____

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

PREMEDS

SELECT BELOW	MEDICATION	DOSE	ROUTE
	BENADRYL, PRN		
	ACETAMINOPHEN, PRN		
	OXYGEN		
	Other:		
	Other:		
	Other:		

LABS

SELECT BELOW	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 NS 50 mL PRN

Physician's Signature _____ Time _____ Date _____

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.



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GENERAL IV ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI _____ DOB: _____
 HT: _____ WT: _____ Sex : () Male () Female SSN: _____ Home #: _____ Cell#: _____
 Street Address _____ City/State/Zip _____
 Allergies: _____

INSURANCE INFORMATION

Primary Insurance Name _____ Policy ID #: _____
 Secondary Insurance Name _____ Policy ID #: _____

PHYSICIAN / FACILITY INFORMATION

Physician Name _____ Contact Name _____ Contact Phone # _____
 Address: _____ City/State/Zip _____
 DEA#: _____ NPI #: _____ State Lic #: _____ 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, what type? PIV (HepLock) PIV (No HepLock – DC after each visit) PICC MediPort

PRESCRIPTION ORDERS

- a) ALL MEDIPOINTS / IV ACCESSES WILL BE FLUSHED WITH HEPARIN OR SALINE PER HOSPITAL PROTOCOL PRN
- b) HOSPITAL PHARMACY WILL FOLLOW AND ADJUST ALL DOSING FOR VANCOMYCIN, GENTAMYCIN, AND PATIENTS WITH RENAL INSUFFICIENCY PER HOSPITAL PROTOCOL

DO NOT ADMINISTER HEPARIN TO THIS PATIENT

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 BELOW	LAB REQUESTED	FREQUENCY	NOTES/INSTRUCTIONS/OTHER
	CBC w/ Diff		_____ _____ _____ _____ _____ _____ _____ _____ _____
	BMP		
	CMP		
	BUN/CREATININE		
	ESR		
	CRP		
	CPK		
	Other:		
	Other:		

FLUSHES: 10 mL NS Flush Syringe PRN Heparin 500 units/5 mL Flush Syringe PRN NS 50 mL PRN

Physician's Signature _____ Time _____ Date _____

Fax completed form to the Outpatient Infusion Center at 1 (877) 249-1191.
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MATAGORDA REGIONAL
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STAT REFERRAL

HYDRATION ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI _____ DOB: _____
 HT: _____ WT: _____ Sex : () Male () Female SSN: _____ Home #: _____ Cell#: _____
 Street Address _____ City/State/Zip _____
 Allergies: _____

INSURANCE INFORMATION

Primary Insurance Name _____ Policy ID #: _____
 Secondary Insurance Name _____ Policy ID #: _____

PHYSICIAN / FACILITY INFORMATION

Physician Name _____ Contact Name _____ Contact Phone # _____
 Address: _____ City/State/Zip _____
 DEA#: _____ NPI #: _____ State Lic #: _____ 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) ALLMEDIPOINTS/IV ACCESS WILL BE ACCESSED AND FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL PROTOCOL

PRESCRIPTION ORDERS FOR HYDRATION

Select the fluid requested AND the corresponding rate below

1.) **NORMAL SALINE**

2.) **LACTATED RINGERS**

<input type="checkbox"/> 500 mls, IV x	<input type="checkbox"/> 500 mls, IV x
<input type="checkbox"/> 1000 mls (1 Liter), IV x	<input type="checkbox"/> 1000 mls (1 Liter), IV x
<input type="checkbox"/> 2000 mls (2 Liters), IV x	<input type="checkbox"/> 2000 mls (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 @ _____ mls/hour	<input type="checkbox"/> Over 2 hours @ _____ mls/hour
<input type="checkbox"/> Over 4 hours @ _____ mls/hour	<input type="checkbox"/> Over 4 hours @ _____ mls/hour
<input type="checkbox"/> Other: _____ mls/hour	<input type="checkbox"/> Other: _____ mls/hour
<input type="checkbox"/> OTHER (PLEASE SPECIFY DRUG, RATE, FREQUENCY, AND DURATION BELOW):	

LABS:

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

NOTES/INSTRUCTIONS/COMMENTS

FLUSHES: Heparin 500 units/5 mL Flush Syringe PRN

Provider's Signature _____ Time _____ Date _____

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.



MATAGORDA REGIONAL
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 MRMCMC IV THERAPY SERVICES
 PHONE: 979-446-0818
 FAX: 1-877-249-1191

INTRAVENOUS IMMUNO GLOBULIN ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI _____ DOB: _____
 HT: _____ WT: _____ Sex : () Male () Female SSN: _____ Home #: _____ Cell#: _____
 Street Address _____ City/State/Zip _____
 Allergies: _____

INSURANCE INFORMATION

Primary Insurance Name _____ Policy ID #: _____
 Secondary Insurance Name _____ Policy ID #: _____

PHYSICIAN / FACILITY INFORMATION

Physician Name _____ Contact Name _____ Contact Phone # _____
 Address: _____ City/State/Zip _____
 DEA#: _____ NPI #: _____ State Lic #: _____ Fax #: _____

STATEMENT OF MEDICAL NECESSITY

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

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

PRESCRIPTION ORDERS: IVIG (DOSES WILL BE ROUNDED TO NEAREST 5 GM or 10 GM INCREMENT TO ELIMINATE WASTE)

Does patient have venous access? YES NO

If yes, what type: MEDIPOINT PIV PICC LINE OTHER: _____

PREFERRED BRAND (substitution may apply): _____

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

PREMEDICATIONS

SELECT BELOW	MEDICATION	DOSE	ROUTE
	BENADRYL, PRN		
	ACETAMINOPHEN, PRN		
	Other:		
	Other:		
	Other:		

LABS

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

NOTES/INSTRUCTIONS/COMMENTS

FLUSHES: 10 mL NS Flush Syringe PRN Heparin 500 units/5 mL Flush Syringe PRN NS 50 mL PRN

Physician's Signature: _____ Time: _____ Date: _____

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.



MATAGORDA REGIONAL
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 MRMCM IV THERAPY SERVICES
 PHONE: 979-446-0818
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RECLAST 5 mg / 100 ml IVPB ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI _____ DOB: _____
 HT: _____ WT: _____ Sex : () Male () Female SSN: _____ Home #: _____ Cell#: _____
 Street Address _____ City/State/Zip _____
 Allergies: _____

INSURANCE INFORMATION

Primary Insurance Name _____ Policy ID #: _____
 Secondary Insurance Name _____ Policy ID #: _____

PHYSICIAN / FACILITY INFORMATION

Physician Name _____ Contact Name _____ Contact Phone # _____
 Address: _____ City/State/Zip _____
 DEA#: _____ NPI #: _____ State Lic #: _____ 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) ALLMEDIPOINTS/IV ACCESS WILL BE ACCESSED AND FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL PROTOCOL

PRESCRIPTION ORDERS

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

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

INCLUDE COPIES OF THE FOLLOWING:

- BUN, CREATININE, and CALCIUM MUST BE CHECKED WITHIN THE LAST 30 DAYS OTHERWISE HOSPITAL WILL COLLECT LABS PRIOR TO INFUSION.
- BONE DENSITY/DEXA SCAN WITHIN THE LAST 2 YEARS – OTHERWISE ONE WILL BE PERFORMED PRIOR TO THE DATE OF SERVICE
- OFFICE NOTES SUPPORTING THE DIAGNOSIS OF OSTEOPOROSIS/OSTEOPENIA DATED WITHIN THE LAST 2 YEARS
- H+P DATED WITHIN THE LAST 2 YEARS
- PRIOR/CURRENT MEDICATIONS USED TO TREAT THE DIAGNOSIS OF OSTEOPOROSIS/OSTEOPENIA MUST BE DOCUMENTED IN PATIENT’S MEDICAL RECORD. Examples: Oral calcium, Vitamin D

Labs Needed: **BUN and CREATININE (if previous results not provided within last 30 days)** _____

Signature: _____ Time: _____ Date: _____

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.



MATAGORDA REGIONAL
 MEDICAL CENTER
 MRMCM IV THERAPY SERVICES
 PHONE: 979-446-0818
 FAX: 1-877-249-1191

REMICADE ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI _____ DOB: _____
 HT: _____ WT: _____ Sex : () Male () Female SSN: _____ Home #: _____ Cell#: _____
 Street Address _____ City/State/Zip _____
 Allergies: _____

INSURANCE INFORMATION

Primary Insurance Name _____ Policy ID #: _____
 Secondary Insurance Name _____ Policy ID #: _____

PHYSICIAN / FACILITY INFORMATION

Physician Name _____ Contact Name _____ Contact Phone # _____
 Address: _____ City/State/Zip _____
 DEA#: _____ NPI #: _____ State Lic #: _____ Fax #: _____

STATEMENT OF MEDICAL NECESSITY ICD-10 Code plus Description _____

PERTINENT MEDICAL HISTORY 1) TB test performed? Yes No Results, _____
 2) Patient diagnosed with Congestive Heart Failure? Yes No 3) Liver function test normal? Yes No
 4) Patient previously treated with Remicade? Yes No Date: _____ 5) Hep-B antigen surface antibody test? Yes No Date: _____
 a) ALL IV ACCESSES WILL BE FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL PROTOCOL
 b) INFlixIMAB WILL BE ADMINISTERED IN NS 0.9% 250 ML OVER NO LESS THAN 2 HOURS WITH A 1.2 MICRON FLITER

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

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

SELECT BELOW	DOSING OPTIONS	DOSE	ROUTE	FREQUENCY (POPULATE BELOW)	DURATION
	LOADING DOSES	MG / KG	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
	OTHER DOSE	MG / KG	IV	ONCE EVERY	WEEKS

LABS

SELECT BELOW	MEDICATION	DOSE	ROUTE
	BENADRYL, PRN		
	ACETAMINOPHEN, PRN		
	OXYGEN		
	Other:		
	Other:		
	Other:		

PREMEDS

SELECT BELOW	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 NS 50 mL PRN

Physician's Signature _____ Time _____ Date _____

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.