Limestone Medical Center
INFUSION CLINIC
Phone: 254-729-4335
Fax: 877-249-1191

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
		LEUKO REDUCED PRBCs
		LEUKO REDUCED IRRADIATED PRBCs
		LEUKO REDUCED PLATELETS
		LEUKO REDUCED IRRADIATED PLATELETS
		PLATELETS TYPE SPECIFIC? ○ Yes OR ○ No
		Other:

LABS

SELECT	LAB REQUESTED	WHEN
	NONE	NA
	BMP	( ) PRIOR ( ) POST
	CMP	( ) PRIOR ( ) POST
	CBC w/ DIFF	( ) PRIOR ( ) POST
	H+H:	( ) PRIOR ( ) POST
	T+C:	( ) PRIOR ( ) POST
	Other:	( ) PRIOR ( ) POST

PREMEDS

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY
	NONE	NA	NA	NA
	BENADRYL			
	ACETAMINOPHEN			
	OXYGEN			
	LASIX			
	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*

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.

Limestone Medical Center
INFUSION CLINIC
Phone: 254-729-4335
Fax: 877-249-1191

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 MEDIPORTS / 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
☐	ENTYVIO (LOADING DOSES)	300 mg	IV	0, 2, 6 WEEKS, THEN ONCE EVERY 8 WEEKS	
☐	ENTYVIO (MAINTENANCE DOSE)	300 mg	IV	ONCE EVERY 8 WEEKS	
☐	RENFLEXIS (LOADING DOSES)	mg / kg	IV	0, 2, 6 WEEKS, THEN ONCE EVERY _____ WEEKS	
☐	RENFLEXIS (MAINTENANCE DOSES)	mg / kg	IV	ONCE EVERY WEEKS	
☐	OTHER:	mg / kg	IV	ONCE EVERY WEEKS	

PREMEDS

SELECT	MEDICATION	DOSE	ROUTE
	NONE	NA	NA
	BENADRYL		
	ACETAMINOPHEN		
	OXYGEN		
	SOLU-MEDROL		
	Other:		
	Other:		
	Other:		
	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	
	ALT	☐ PRIOR ☐ POST	
	AST	☐ PRIOR ☐ POST	
	LIVER PANEL	☐ PRIOR ☐ POST	
	VECTRA	☐ PRIOR ☐ POST	
	OTHER:	☐ PRIOR ☐ 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 1 (877) 249-1191.

Limestone Medical Center
INFUSION CLINIC
Phone: 254-729-4335
Fax: 877-249-1191

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

SELECT BELOW	LAB REQUESTED	FREQUENCY
	NONE	**NA**
	CBC w/ Diff	
	BMP	
	CMP	
	BUN/CREATININE	
	ESR	
	CRP	
	CPK	
	Other:	
	Other:	

NOTES/INSTRUCTIONS/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 1 (877) 249-1191.

LMC
Limestone
Medical Center
INFUSION CLINIC
Phone: 254-729-4335
Fax: 877-249-1191

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**
☐ **500 mL, IV x**	☐ **500 mL, IV x**
☐ **1000 mL (1 Liter), IV x**	☐ **1000 mL (1 Liter), IV x**
☐ **2000 mL (2 Liters), IV x**	☐ **2000 mL (2 Liters), IV x**
RATE	**RATE**
☐ **BOLUS - GIVEN OVER 1 HOUR**	☐ **BOLUS - GIVEN OVER 1 HOUR**
☐ **Over 2 hours @ mL/hour**	☐ **Over 2 hours @ mL/hour**
☐ **Over 4 hours @ mL/hour**	☐ **Over 4 hours @ mL/hour**
☐ **Other: mL/hour**	☐ **Other: mL/hour**

☐ _____ **MEQ K+** ○ _____**MG MAG** ○ _____ **Lidocaine 1% 2 mL** ○ **OTHER:**_____**RATE MAY BE ADJUSTED PER HOSPITAL POLICY**

(K+ max rate of 10mEq/hr)

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

_____

_____

_____

_____

_____

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 1 (877) 249-1191.

LMC
Limestone
Medical Center
INFUSION CLINIC
Phone: 254-729-4335
Fax: 877-249-1191

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
	TYSABRI 300 mg ***PATIENT WILL BE OBSERVED FOR 1 HOUR POST INFUSION***	**IV**		**12 MONTHS**
	OCREVUS LOADING DOSES	**IV**	**300 mg at 0, 2 weeks, then 600mg once every 6 months**	
	OCREVUS 600 mg MAINTENANCE DOSES	**IV**	**Once every 6 months**	
	SOLU-MEDROL mg	**IV**		

PREMEDS

SELECT	MEDICATION	DOSE	ROUTE
	BENADRYL		
	ACETAMINOPHEN		
	SOLUMEDROL		
	OXYGEN		
	FAMOTIDINE		
	Other:		
	Other:		

LABS

SELECT	LAB REQUESTED	WHEN	FREQUENCY
	BMP	☐ **PRIOR** ☐ **POST**	
	CMP	☐ **PRIOR** ☐ **POST**	
	BUN/CREATININE	☐ **PRIOR** ☐ **POST**	
	JCV ANTIBODY (Patients taking Tysabri)	**(X) PRIOR ( ) POST**	**EVERY 6 MONTHS**
	CRP	☐ **PRIOR** ☐ **POST**	
	ESR	☐ **PRIOR** ☐ **POST**	
	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*

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.

Limestone Medical Center
INFUSION CLINIC
Phone: 254-729-4335
Fax: 877-249-1191

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** ☐ **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	DOSE	ROUTE	RATE	REPEAT EVERY	DURATION
	mg / kg	**IV**	**TITRATE PER POLICY**		
	Flat Dose: gm	**IV**	**TITRATE PER POLICY**		

PREMEDS

SELECT	MEDICATION	DOSE	ROUTE
	BENADRYL		
	ACETAMINOPHEN		
	SOLUMEDROL		
	FAMOTIDINE		
	Other:		

LABS

SELECT	LAB REQUESTED	WHEN	FREQUENCY
	BMP	☐ PRIOR ☐ POST	
	CMP	☐ PRIOR ☐ POST	
	BUN/CREATININ	☐ PRIOR ☐ POST	
	Other:	☐ PRIOR ☐ POST	
	Other:	☐ PRIOR ☐ 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*

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.

Limestone Medical Center
INFUSION CLINIC
Phone: 254-729-4335
Fax: 877-249-1191

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
	RECLAST (ZOLEDRONIC ACID) ADMINISTER OVER NO LESS THAN 15 MINUTES BUN, CREAT, AND CALCIUM LEVEL WITHIN 90 DAYS OF APPOINTMENT HOLD IF CALCIUM LEVELS < 8.5mg/dL or IONIZED CALCIUM LEVEL < 4.5mg/dL or IF CRCL < 35 ML/MIN	**5 mg**	**IV**	**ONCE EVERY 12 MONTHS**	**1 Year**
	PROLIA (DENOSUMAB) BUN, CREAT, CALCIUM LEVEL WITIN 90 DAYS OF THE APPOINTMENT HOLD IF CALCIUM LEVELS < 8.5mg/dL or IONIZED CALCIUM LEVEL < 4.5mg/dL or IF CRCL < 30 ML/MIN	**60 mg**	**SC**	**ONCE EVERY 6 MONTHS**	**1 Year**
	EVENITY BUN, CREAT, CALCIUM LEVEL WITIN 90 DAYS OF THE APPOINTMENT HOLD IF CALCIUM LEVELS < 8.5 mg/dL or IONIZED CALCIUM LEVEL < 4.5 mg/dL or IF CRCL < 30 ML/MIN	**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 MADD 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 DENISTY 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 1 (877) 249-1191.

Limestone Medical Center
INFUSION CLINIC
Phone: 254-729-4335
Fax: 877-249-1191

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 ≥ to _12 g/dL__

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY	DURATION
	Aranesp				
	Neulasta				
	Neupogen (Granix Substitute)				
	Procrit ESRD *(Patients on Dialysis)*				
	Procrit NON ESRD				
	Retacrit ESRD *(Patients on Dialysis)*				
	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*

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.

Limestone Medical Center
INFUSION CLINIC
Phone: 254-729-4335
Fax: 877-249-1191

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
	XOLAIR	☐ 150 mg ☐ 225 mg ☐ 300 mg ☐ 375 mg	SQ	Every _____ days	
	FASENRA (LOADING DOSES)	30 mg	SQ	Every 4 weeks for 3 doses, then every 8 weeks	
	FASENRA (MAINTENANCE DOSES)	30 mg	SQ	Every 8 weeks	
	NUCALA	100 MG	SQ	Every 4 weeks	
	TEZSPIRE	210 mg	SQ	Every 4 weeks	

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*

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.

Limestone Medical Center
INFUSION CLINIC
Phone: 254-729-4335
Fax: 877-249-1191

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,_____

4) Hep-B antigen surface antibody test? ○ Yes ○ No Date: _____

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

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

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

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

PREMEDS

SELECT	MEDICATION	DOSE	ROUTE
	NONE	NA	NA
	BENADRYL		
	ACETAMINOPHEN		
	OXYGEN		
	SOLU-MEDROL		
	ONDANSETRON		
	FAMOTIDINE		
	Other:		
	Other:		
	Other:		

LABS

SELECT	LAB REQUESTED	WHEN	FREQUENCY
	NONE	NA	NA
	BMP		
	CMP		
	BUN/CREATININE		
	CRP		
	ESR		
	ALT		
	AST		
	LIVER PANEL		
	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 1 (877) 249-1191.

LMC
Limestone
Medical Center
INFUSION CLINIC
Phone: 254-729-4335
Fax: 877-249-1191

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 MEDIPORTS/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
	VENOFER	**mg**	**IV**		
	VENOFER	**200 mg**	**IV**	**ONCE EVERY WEEK**	**5 Doses**
	INJECTAFER	**750 mg**	**IV**	**ONCE EVERY WEEK**	**2 Weeks**
	FERRLECIT	**125 mg**	**IV**		
	FERRLECIT	**250 mg**	**IV**		
	FERAHEME	**510 mg**	**IV**	**ONCE, THEN REPEAT 3 – 8 DAYS LATER**	**2 Doses**
	OTHER:				

PREMEDS

SELECT BELOW	MEDICATION	DOSE	ROUTE
	NONE	**NA**	**NA**
	BENADRYL	**50 mg**	**IV**
	ACETAMINOPHEN		
	OXYGEN		
	EPINEPHRINE	**0.3mg / 0.3mL**	**IM**
	SOLU-MEDROL	**125 mg**	**IV**
	Other:		

LABS

SELECT BELOW	LAB REQUESTED	WHEN	FREQUENCY
	NONE	**NA**	**NA**
	BMP	☐ **PRIOR** ☐ **POST**	
	CMP	☐ **PRIOR** ☐ **POST**	
	BUN/CREATININE	☐ **PRIOR** ☐ **POST**	
	H+H:	☐ **PRIOR** ☐ **POST**	
	Ferritin:	☐ **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*

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.

Limestone Medical Center
INFUSION CLINIC
Phone: 254-729-4335
Fax: 877-249-1191

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 MEDIPORTS / 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

	mL TO REMOVE (+/- 50 mL)	PARAMATERS	FREQUENCY	DURATION
Therapeutic Phlebotomy		**HOLD if ≤**	☐ **1 x only** ☐ **Weekly** ☐ **Monthly** ☐ **Other:**	

LABS

SELECT BELOW	LAB REQUESTED	FREQUENCY
	NONE	**NA**
	CBC w/ Diff	**PRIOR TO EACH PHLEBOTOMY**
	Hgb	**PRIOR TO EACH PHLEBOTOMY**
	Hct	**PRIOR TO EACH PHLEBOTOMY**
	BMP	
	CMP	
	BUN/CREATININE	
	ESR	
	CRP	
	CPK	
	Ferritin	
	Other:	
	Other:	

NOTES/INSTRUCTIONS/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 1 (877) 249-1191.

Limestone Medical Center
INFUSION CLINIC
Phone: 254-729-4335
Fax: 877-249-1191

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** ☐ **MEDIPORT** ☐ **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
	BENADRYL				
	COMPAZINE				
	DEPACON				
	DHE 45				
	DILANTIN				
	KEPPRA				
	KETOROLAC				
	METHYLPREDNISOLONE				
	METOCLOPRAMIDE				
	ORPHENADRINE				
	PROMETHAZINE				
	VYEPTI	100 mg	IV	Once Every 3 Months	
	0.9% NS				

PREMEDS

SELECT BELOW	MEDICATION	DOSE	ROUTE
	NONE	NA	NA
	BENADRYL		IV
	ACETAMINOPHEN		
	OXYGEN		
	ZOFRAN		IV
	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	

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 1 (877) 249-1191.

Limestone Medical Center
INFUSION CLINIC
Phone: 254-729-4335
Fax: 877-249-1191

☐ **STAT REFERRAL**

ANTIBIOTICS 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 POLICY UNTIL LINE IS REMOVED

a) ALL MEDIPORTS/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
	Vancomycin	500 mg	IV		
	Vancomycin	750 mg	IV		
	Vancomycin	1000 mg	IV		
	Vancomycin	1500 mg	IV		
	Vancomycin	1750 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		

SELECT	DRUG	DOSE	ROUTE	REPEAT EVERY	DURATION
	Invanz (Ertapenem)	1000 mg	( ) IV ( ) IM		
	Merrem (Meropenem)	500 mg	( ) IV		
	Merrem (Meropenem)	1000 mg	( ) IV		
	Gentamicin (Garamycin)		( ) IV		
	Gentamicin (Garamycin)	7mg/kg	( ) 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		

OTHER MEDICATION (not listed):

SELECT	LAB REQUESTED	WHEN	FREQUENCY
	NONE	NA	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	FREQUENCY
	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*

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 1 (877) 249-1191.

Limestone Medical Center
INFUSION CLINIC
Phone: 254-729-4335
Fax: 877-249-1191

☐ **STAT REFERRAL**

LEQEMBI 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 #: _____

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
□ G30.1 Alzheimer's Disease, Late Onset
□ G30.8 Other Alzheimer's disease
□ G30.9 Alzheimer's disease, unspecified
□ G31.84 Mild Cognitive Impairment, So Stated
← G30.X codes require secondary F02.8X code →
□ F02.80 Dementia without behavioral disturbance
□ F02.81 Dementia with behavioral disturbance
□ Other:_____ (ICD 10 + Description)

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 1 (877) 249-1191.

Limestone
Medical Center
INFUSION CLINIC
Phone: 254-729-4335
Fax: 877-249-1191

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
	COSYNTROPIN 250 MCG/2 mL (NS)	2 mL	IV Push over 2 minutes	ONCE	1

LABS

SELECT BELOW	LAB REQUESTED	FREQUENCY
X	ACTH LEVEL	PRIOR
X	CORTISOL LEVEL	PRIOR AND REPEAT 30 + 60 MINUTES POST INFUSION
	Other:	
	Other:	
	Other:	
	Other:	

NOTES/INSTRUCTIONS/OTHER

_____
_____
_____
_____
_____
_____

1) **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**

2) **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 1 (877) 249-1191.

Limestone Medical Center
INFUSION CLINIC
Phone: 254-729-4335
Fax: 877-249-1191

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
	LEQVIO (LOADING DOSES)	284 mg	SQ	Month 0 and 3, then every 6 months	
	LEQVIO (MAINTENANCE DOSES)	284 mg	SQ	Every 6 months	

LABS

SELECT BELOW	LAB REQUESTED	FREQUENCY

SUPPORTING DOCUMENTATION FOR PATIENTS RECEIVING LEQVIO

1) **SUPPORTING CLINICAL NOTES TO INCLUDE ANY PAST TRIED AND/OR FAILED THERAPIES, INTOLERANCE, BENEFITS, OR CONTRAINDICATIONS TO CONVENTIONAL THERAPY**

2) **HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HEFH) - DOES THE PATIENT HAVE A UNTREATED LDL ≥ 190MG/DL (≥ 155MG/DL IF <16 YEARS OF AGE)? ☐ YES ☐ NO**

3) **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**

4) **ASCVD - DOES THE PATIENT'S LDL REMAIN ≥ 100MG/DL DESPITE TREATMENT WITH A HIGH-INTENSITY STATIN? ☐ YES ☐ NO**

5) **HAS THE PATIENT TRIED AND FAILED PCSK9 INHIBITOR AFTER 12 WEEKS OF USE? ☐ YES ☐ NO**

6) **HAS THE PATIENT TRIED AND FAILED A HIGH INTENSITY STATIN FOR ≥ 8 CONTINUOUS WEEKS? ☐ YES ☐ NO**

7) **INDICATE ANY CONDITIONS THE PATIENT HAS:**
   - ☐ **ACUTE CORONARY SYNDROME**
   - ☐ **CORONARY OR OTHER ARTERIAL REVASCULARIZATION**
   - ☐ **PERIPHERAL ARTERIAL DISEASE PRESUMED TO BE OF ATHEROSCLEROTIC ORIGIN**
   - ☐ **HISTORY OF MYOCARDIAL INFARCTION**
   - ☐ **TRANSIENT ISCHEMIC ATTACK**
   - ☐ **STROKE**

8) **INCLUDE LABS AND/OR TEST RESULTS TO SUPPORT DIAGNOSIS**
   - ☐ **LDL-C (Required)**
   - ☐ **MUTATION IN LDL, APOB, OR PCSK9 GENE (If Applicable)**

9) **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*

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.