

ACCEPTING REFERRALS



McAlester Regional Outpatient Infusion Center

AN AFFILIATE OF McALESTER REGIONAL HEALTH CENTER






Our dedicated team is trained to provide cutting-edge **Infusion Therapy Services** allowing quality care close to home.

Partial List of Diseases Treated

Osteoporosis	Allergic Rhinitis
Crohn's Disease	Skin/Bone Infection
Multiple Sclerosis	Anemia
Polycythemia Vera	PICC Line Care
Rheumatoid Arthritis	Port Flushes
Ulcerative Colitis	More!

Why Choose Us

-  Dedicated care coordinator to ensure patients get the services they need
-  Patient assistance enrollment and flexible scheduling options
-  On-demand insurance verification and authorization services



Proven Patient Support

Care Coordination Services for Every Patient to ensure Every Infusion...Every Time



Convenience

Patients benefit from reduced travel expenses and are able to receive the care closer to home



Authorization Services

Our dedicated team will complete the authorization process on behalf of the provider

Contact Now



918-421-6849



877-249-1191



1 Clark Bass Blvd,
McAlester, OK 74501





McAlester Regional Outpatient Infusion Center

AN AFFILIATE OF McALESTER REGIONAL HEALTH CENTER



How to Make a Referral

- ✓ Use the Infusion Center **"IV Infusion Order Form"**
 - ✓ Complete all required information or submit along with a face sheet.
 - ✓ **Fax "IV Infusion Order Form"** with patient information to the toll-free fax number, **877-249-1191**.
 - ✓ **Call care coordination** at **918-421-6849** to notify the Infusion Center care coordination team.
 - ✓ The patient's benefits will be verified and the appointment will be scheduled.
- Authorization will be completed by our dedicated care coordination team. To expedite the process, please submit all supporting medical records and office notes along with the referral.

[STAT/URGENT REFERRALS WILL RECEIVE IMMEDIATE ATTENTION. CALL 918-421-6849 TO EXPEDITE THE PROCESS.](#)



918-421-6849



877-249-1191



1 Clark Bass Blvd,
McAlester, OK 74501





McAlester Regional Outpatient Infusion Center

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Partial Medication Listing

Actemra	Solu-Medrol
Albumin	Mycamine
Ancef	Neulasta
Aranesp	Neupogen
Azactam	Nucala
Benlysta	Ocrevus
Cefazolin	Orencia
Cimzia	Penicillin
Ciprofloxacin	Procrit
Cleocin	Prolia
Dalvance	Radicava
Daptomycin	Reclast
DHE 45	Remicade
Evenity	Rifampin
Fasenra	Rituxan
Flagyl	Rocephin
Fortaz	Simponi Aria
Gentamicin	Soliris
Invanz	Teflaro
IV Iron	Tezspire
IVIg	Tobramycin
Keflex	Tysabri
Leqvio	Vancomycin
Levaquin	Vyepti
Lupron	Xolair
Merrem	Zometa



918-421-6849



877-249-1191



1 Clark Bass Blvd,
McAlester, OK 74501



STAT REFERRAL

BLOOD PRODUCT TRANSFUSION ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ DOB: _____

HT: _____ in WT: _____ lbs 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 MEDIPOINT 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 MEDIPOINTS / 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:	

PREMEDS

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY
<input type="checkbox"/>	NONE	NA	NA	NA
<input type="checkbox"/>	BENADRYL	<input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg	<input type="checkbox"/> PO <input type="checkbox"/> IV	<input type="checkbox"/> ONCE <input type="checkbox"/> PRN
<input type="checkbox"/>	ACETAMINOPHEN	<input type="checkbox"/> 500 mg <input type="checkbox"/> 650 mg	PO	<input type="checkbox"/> ONCE <input type="checkbox"/> PRN
<input type="checkbox"/>	FUROSEMIDE	<input type="checkbox"/> 20 mg <input type="checkbox"/> 40 mg <input type="checkbox"/> 80 mg	IV	<input type="checkbox"/> ONCE <input type="checkbox"/> PRN
<input type="checkbox"/>	HEPARIN FLUSH	500 units	IV	<input type="checkbox"/> ONCE <input type="checkbox"/> PRN
<input type="checkbox"/>	SODIUM CHLORIDE 0.9%	100 mL (for IV Flush)	IV	<input type="checkbox"/> ONCE <input type="checkbox"/> PRN
<input type="checkbox"/>	OXYGEN			
<input type="checkbox"/>	OTHER:			
<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*

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

STAT REFERRAL

GASTROENTEROLOGY ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ DOB: _____

HT: _____ in WT: _____ lbs 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 MEDIPOINT 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
- d) RENFLEXIS DOSING WILL BE ROUNDED TO THE NEAREST 100MG VIAL

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	FREQUENCY
<input type="checkbox"/>	NONE	NA	NA	NA
<input type="checkbox"/>	BENADRYL	<input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg	<input type="checkbox"/> PO <input type="checkbox"/> IV	<input type="checkbox"/> ONCE <input type="checkbox"/> PRN
<input type="checkbox"/>	ACETAMINOPHEN	<input type="checkbox"/> 500 mg <input type="checkbox"/> 650 mg	PO	<input type="checkbox"/> ONCE <input type="checkbox"/> PRN
<input type="checkbox"/>	SOLU-MEDROL	<input type="checkbox"/> 40 mg <input type="checkbox"/> 125 mg	IV	<input type="checkbox"/> ONCE <input type="checkbox"/> PRN
<input type="checkbox"/>	OXYGEN			
<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"/>	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:		

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

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**McAlester Regional
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Phone: 918-421-6849 Fax: 877-249-1191

STAT REFERRAL

GENERAL IV ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ DOB: _____

HT: _____ in WT: _____ lbs 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 MEDIPOINT PIV PICC LINE OTHER: _____

PRESCRIPTION ORDERS

- a) ALL MEDIPOINTS / 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*

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STAT REFERRAL

HYDRATION ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ DOB: _____

HT: _____ in WT: _____ lbs 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 MEDIPOINT PIV PICC LINE OTHER: _____

a) ALL MEDIPOINTS/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.) <input type="checkbox"/> NORMAL SALINE	2.) <input type="checkbox"/> LACTATED RINGERS	3.) <input type="checkbox"/> RALLY PACK / BANANA BAG
<input type="checkbox"/> 500 mL, IV x _____	<input type="checkbox"/> 500 mL, IV x _____	SODIUM CHLORIDE 0.9%: 1000 mL THIAMINE: 100 mg MAGNESIUM SULFATE: 2 g INFUVITE – MVI: 10 mL FOLIC ACID: 2 mg
<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	RATE
<input type="checkbox"/> BOLUS - GIVEN OVER 1 HOUR	<input type="checkbox"/> BOLUS - GIVEN OVER 1 HOUR	<input type="checkbox"/> 500 mL/hour
<input type="checkbox"/> Over 2 hours @ _____ mL/hour	<input type="checkbox"/> Over 2 hours @ _____ mL/hour	<input type="checkbox"/> Other: _____ 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	

_____ 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	LAB REQUESTED	WHEN
<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:	

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*

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**McAlester Regional
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Phone: 918-421-6849 Fax: 877-249-1191

STAT REFERRAL

NEUROLOGY ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ DOB: _____

HT: _____ in WT: _____ lbs 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	MEDICATION / DOSE	ROUTE	FREQUENCY	DURATION
<input type="checkbox"/>	TYSABRI 300 mg <i>*PATIENT WILL BE OBSERVED FOR 1 HOUR POST INFUSION</i>	IV	ONCE EVERY 4 WEEKS	12 MONTHS
<input type="checkbox"/>	OCREVUS LOADING DOSES	IV	300 mg AT 0, 2 WEEKS, THEN 600 mg ONCE EVERY 6 MONTHS	
<input type="checkbox"/>	OCREVUS 600 mg MAINTENANCE DOSES	IV	ONCE EVERY 6 MONTHS	
<input type="checkbox"/>	SOLU-MEDROL <input type="checkbox"/> 500 mg <input type="checkbox"/> 1000 mg	IV	DAILY	<input type="checkbox"/> 3 DAYS <input type="checkbox"/> 5 DAYS

PREMEDS

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY
<input type="checkbox"/>	BENADRYL	<input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg	<input type="checkbox"/> PO <input type="checkbox"/> IV	<input type="checkbox"/> ONCE <input type="checkbox"/> PRN
<input type="checkbox"/>	ACETAMINOPHEN	<input type="checkbox"/> 500 mg <input type="checkbox"/> 650 mg	PO	<input type="checkbox"/> ONCE <input type="checkbox"/> PRN
<input type="checkbox"/>	SOLU-MEDROL	<input type="checkbox"/> 40 mg <input type="checkbox"/> 125 mg	IV	<input type="checkbox"/> ONCE <input type="checkbox"/> PRN
<input type="checkbox"/>	FAMOTIDINE	<input type="checkbox"/> 20 mg <input type="checkbox"/> 40 mg	<input type="checkbox"/> PO <input type="checkbox"/> IV	<input type="checkbox"/> ONCE <input type="checkbox"/> PRN
<input type="checkbox"/>	OXYGEN			
<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*

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

STAT REFERRAL

INTRAVENOUS IMMUNE GLOBULIN ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ DOB: _____

HT: _____ in WT: _____ lbs 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 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
- d) DOSES WILL BE ROUNDED TO THE NEAREST 5 GM

PRIVIGEN (J1459) WILL BE ADMINISTERED UNLESS OTHERWISE INDICATE HERE: _____

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

PREMEDS

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY
<input type="checkbox"/>	BENADRYL	<input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg	<input type="checkbox"/> PO <input type="checkbox"/> IV	<input type="checkbox"/> ONCE <input type="checkbox"/> PRN
<input type="checkbox"/>	ACETAMINOPHEN	<input type="checkbox"/> 500 mg <input type="checkbox"/> 650 mg	PO	<input type="checkbox"/> ONCE <input type="checkbox"/> PRN
<input type="checkbox"/>	SOLUMEDROL	<input type="checkbox"/> 40 mg <input type="checkbox"/> 125 mg	IV	<input type="checkbox"/> ONCE <input type="checkbox"/> PRN
<input type="checkbox"/>	FAMOTIDINE	<input type="checkbox"/> 20 mg <input type="checkbox"/> 40 mg	<input type="checkbox"/> PO <input type="checkbox"/> IV	<input type="checkbox"/> ONCE <input type="checkbox"/> PRN
<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"/>	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*

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



**McAlester Regional
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Phone: 918-421-6849 Fax: 877-249-1191

STAT REFERRAL

OSTEOPOROSIS / OSTEOPENIA ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ DOB: _____

HT: _____ in WT: _____ lbs 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"/>	SELECT ONE: <input type="checkbox"/> PROLIA <input type="checkbox"/> CONEXENCE <input type="checkbox"/> JUBBONTI <input type="checkbox"/> STOBOCLO (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

LAB ORDERS: Calcium, BUN, Serum Creatinine will be drawn prior to administration if previous results not provided within 90 days of appointment.

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

- 1) **OSTEOPOROSIS / OSTEOPENIA:**
 - 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 OR OSTEOPENIA.
 - ORIGINAL 10 YEAR FRAX PROBABILITY SUPPORTING HIGH RISK FOR FUTURE FRACTURES (OSTEOPENIA DIAGNOSIS).
 - H+P OR OFFICE NOTES LISTING THE DIAGNOSIS OF OSTEOPOROSIS OR OSTEOPENIA IN THE PATIENT RECORD DATED WITHIN 1 YEAR PRIOR TO APPOINTMENT
 - PRIOR/CURRENT MEDICATIONS USED TO TREAT THE DIAGNOSIS OF OSTEOPOROSIS OR OSTEOPENIA 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 AN APPROVED DIAGNOSIS FOR RECLAST (ZOLEDRONIC ACID) WITH AN ASSOCIATION TO EITHER LOWER ENERGY FRACTURE (FRAGILITY FRACTURE) OR A HIGH RISK FOR FUTURE FRACTURES INDICATED BY THE PATIENTS 10 YEAR FRAX PROBABILITY.

*OSTEOPENIA IS NOT AN APPROVED DIAGNOSIS FOR PROLIA (DENOSUMAB) OR EVENITY. PATIENTS WITH IMPRESSIONS OF OSTEOPENIA MUST HAVE AN ORIGINAL BONE DENSITY RESULT OR DEXA SCAN SUPPORTING THE DIAGNOSIS OF OSTEOPOROSIS OR DOCUMENTATION OF A LOWER ENERGY FRACTURE (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.

STAT REFERRAL

BONE MARROW STIMULATING AGENTS ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ DOB: _____

HT: _____ in WT: _____ lbs 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"/>	RETACRIT ESRD (<i>Patients on Dialysis</i>)				
<input type="checkbox"/>	RETACRIT NON ESRD				
<input type="checkbox"/>	ZARXIO (<i>Granix Substitute</i>)				
<input type="checkbox"/>	ARANESP				
<input type="checkbox"/>	NEULASTA				
<input type="checkbox"/>	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.



McAlester Regional Outpatient Infusion Center

AN AFFILIATE OF McALESTER REGIONAL HEALTH CENTER
Phone: 918-421-6849 Fax: 877-249-1191

STAT REFERRAL

ASTHMA AGENTS

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ DOB: _____

HT: _____ in WT: _____ lbs 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	FREQUENCY
<input type="checkbox"/>	NONE	NA	NA	NA
<input type="checkbox"/>	BENADRYL	<input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg	<input type="checkbox"/> PO <input type="checkbox"/> IV	<input type="checkbox"/> ONCE <input type="checkbox"/> PRN
<input type="checkbox"/>	ACETAMINOPHEN	<input type="checkbox"/> 500 mg <input type="checkbox"/> 650 mg	PO	<input type="checkbox"/> ONCE <input type="checkbox"/> PRN
<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:		

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.



McAlester Regional Outpatient Infusion Center

AN AFFILIATE OF MCALESTER REGIONAL HEALTH CENTER

Phone: 918-421-6849 Fax: 877-249-1191

STAT REFERRAL

RHEUMATOLOGY ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ DOB: _____

HT: _____ in WT: _____ lbs 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 ACCESSSES 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

d) WEIGHT BASED MEDICATION WILL BE ROUNDED TO THE NEAREST 100 MG VIAL

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"/>	INFLECTRA LOADING DOSE(S)	_____ mg / kg	IV	0, 2, 6 WEEKS, THEN ONCE EVERY _____ WEEKS	
<input type="checkbox"/>	INFLECTRA 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)	_____ mg	IV	ONCE	1
	<i>*SC administration is NOT covered Outpatient</i>				

PREMEDS

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY
<input type="checkbox"/>	NONE	NA	NA	
<input type="checkbox"/>	BENADRYL	<input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg	<input type="checkbox"/> PO <input type="checkbox"/> IV	<input type="checkbox"/> ONCE <input type="checkbox"/> PRN
<input type="checkbox"/>	ACETAMINOPHEN	<input type="checkbox"/> 500 mg <input type="checkbox"/> 650 mg	PO	<input type="checkbox"/> ONCE <input type="checkbox"/> PRN
<input type="checkbox"/>	SOLU-MEDROL	<input type="checkbox"/> 40 mg <input type="checkbox"/> 125 mg	IV	<input type="checkbox"/> ONCE <input type="checkbox"/> PRN
<input type="checkbox"/>	ONDANSETRON	4 mg	<input type="checkbox"/> PO <input type="checkbox"/> IV	<input type="checkbox"/> ONCE <input type="checkbox"/> PRN
<input type="checkbox"/>	FAMOTIDINE	<input type="checkbox"/> 20 mg <input type="checkbox"/> 40 mg	<input type="checkbox"/> PO <input type="checkbox"/> IV	<input type="checkbox"/> ONCE <input type="checkbox"/> PRN
<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"/>	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"/>	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.

STAT REFERRAL

IRON PRODUCTS ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ DOB: _____

HT: _____ in WT: _____ lbs 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

MEDICATION SUBSTITUTION MAY APPLY PER HOSPITAL PROTOCOL AND PAYOR PREFERENCE

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY	DURATION
<input type="checkbox"/>	FERAHEME (Preferred)	510 mg	IV	ONCE, THEN REPEAT 3 - 8 DAYS LATER	2 DOSES
<input type="checkbox"/>	VENOFER	___mg	IV		
<input type="checkbox"/>	VENOFER	200 mg	IV	ONCE EVERY WEEK	5 DOSES
<input type="checkbox"/>	FERRLECIT	125 mg	IV		
<input type="checkbox"/>	FERRLECIT	250 mg	IV		
<input type="checkbox"/>	MONOFERRIC	___mg	IV		
<input type="checkbox"/>	MONOFERRIC	1000 mg	IV	ONCE	1 DOSE
<input type="checkbox"/>	INJECTAFER	750 mg	IV	ONCE EVERY WEEK	2 WEEKS
<input type="checkbox"/>	OTHER:				

PREMEDS

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY
<input type="checkbox"/>	NONE	NA	NA	NA
<input type="checkbox"/>	BENADRYL	50 mg	IV	<input type="checkbox"/> ONCE <input type="checkbox"/> PRN
<input type="checkbox"/>	ACETAMINOPHEN	<input type="checkbox"/> 500 mg <input type="checkbox"/> 650 mg	PO	<input type="checkbox"/> ONCE <input type="checkbox"/> PRN
<input type="checkbox"/>	EPINEPHRINE	0.3mg / 0.3mL	IM	<input type="checkbox"/> ONCE <input type="checkbox"/> PRN
<input type="checkbox"/>	SOLU-MEDROL	125 mg	IV	<input type="checkbox"/> ONCE <input type="checkbox"/> PRN
<input type="checkbox"/>	OXYGEN			
<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:		

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.



**McAlester Regional
Outpatient Infusion Center**

AN AFFILIATE OF McALESTER REGIONAL HEALTH CENTER
Phone: 918-421-6849 Fax: 877-249-1191

STAT REFERRAL

THERAPEUTIC PHLEBOTOMY ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ DOB: _____

HT: _____ in WT: _____ lbs 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)	PARAMATERS	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 1 (877) 249-1191.



McAlester Regional Outpatient Infusion Center

AN AFFILIATE OF McALESTER REGIONAL HEALTH CENTER
Phone: 918-421-6849 Fax: 877-249-1191

STAT REFERRAL

HEADACHE ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ DOB: _____

HT: _____ in WT: _____ lbs 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 ORDER

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY	DURATION
<input type="checkbox"/>	BENADRYL				
<input type="checkbox"/>	COMPAZINE				
<input type="checkbox"/>	VALPROATE SODIUM	<input type="checkbox"/> 500 mg <input type="checkbox"/> 1000mg	IV		
<input type="checkbox"/>	DIHYDROERGOTAMINE	1 mg	<input type="checkbox"/> IM <input type="checkbox"/> IV <input type="checkbox"/> SQ		
<input type="checkbox"/>	CEREBYX				
<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"/> 25 mg <input type="checkbox"/> 50 mg	IM		
<input type="checkbox"/>	VYEPTI	100 mg	IV	ONCE EVERY 3 MONTHS	
<input type="checkbox"/>	VYEPTI	300 mg	IV	ONCE EVERY 3 MONTHS	
<input type="checkbox"/>	0.9% NS				

PREMEDS

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY
<input type="checkbox"/>	NONE	NA	NA	
<input type="checkbox"/>	BENADRYL	<input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg	<input type="checkbox"/> PO <input type="checkbox"/> IV	<input type="checkbox"/> ONCE <input type="checkbox"/> PRN
<input type="checkbox"/>	ACETAMINOPHEN	<input type="checkbox"/> 500 mg <input type="checkbox"/> 650 mg	PO	<input type="checkbox"/> ONCE <input type="checkbox"/> PRN
<input type="checkbox"/>	ONDANSETRON	4 mg	<input type="checkbox"/> PO <input type="checkbox"/> IV	<input type="checkbox"/> ONCE <input type="checkbox"/> PRN
<input type="checkbox"/>	OXYGEN			<input type="checkbox"/> ONCE <input type="checkbox"/> PRN
<input type="checkbox"/>	ZOFRAN		IV	<input type="checkbox"/> ONCE <input type="checkbox"/> PRN
<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:		

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.

STAT REFERRAL

ANTIBIOTICS ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ DOB: _____

HT: _____ in WT: _____ lbs 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)	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		
<input type="checkbox"/>			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"/>	Other:		
<input type="checkbox"/>	Other:		
<input type="checkbox"/>	Other:		
<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 1 (877) 249-1191.

STAT REFERRAL

LEQEMBI ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ DOB: _____

HT: _____ in WT: _____ lbs 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 MEDIPOINT PIV PICC LINE OTHER: _____

- a) ALL MEDIPOINTS / 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 ← G30.X codes require secondary F02.8X code → 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)

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
- CMS Alzheimer National Patient Registry Number: ALZH - _____ National Clinical Trial Number: NCT - _____

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 3rd, 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.

KISUNLA ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ DOB: _____

HT: _____ in WT: _____ lbs 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 MEDIPOINT PIV PICC LINE OTHER: _____

- c) ALL MEDIPOINTS / IV ACCESSES WILL BE FLUSHED WITH HEPARIN OR SALINE PER HOSPITAL PROTOCOL PRN
- d) 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
 - Other: _____ (ICD 10 + Description)
- ← G30.X codes require secondary F02.8X code →
- F02.80 Dementia without behavioral disturbance
 - F02.81 Dementia with behavioral disturbance

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
- CMS Alzheimer National Patient Registry Number: ALZH - _____ National Clinical Trial Number: NCT - _____

PRESCRIPTION ORDERS

SELECT	DRUG	TITRATED DOSING	ROUTE	TITRATED SCHEDULE	DURATION
<input type="checkbox"/>	Kisunla	350 mg	IV Over At Least 30 Minutes	Infusion 1	1 time
<input type="checkbox"/>	Kisunla	700 mg	IV Over At Least 30 Minutes	Infusion 2 (4 weeks after infusion 1)	1 time
<input type="checkbox"/>	Kisunla	1050 mg	IV Over At Least 30 Minutes	Infusion 3 (4 weeks after infusion 2)	1 time
<input type="checkbox"/>	Kisunla	1400 mg	IV Over At Least 30 Minutes	Infusion 4 and Beyond (4 weeks after infusion 3 and then every 4 weeks thereafter)	12 Months

Pre-Infusion:

- Confirm baseline MRI results prior to initiation of treatment.
- Confirm MRI completed and reviewed by prescriber prior to the 2nd, 3rd, 4th and 7th 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

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**McAlester Regional
Outpatient Infusion Center**

AN AFFILIATE OF McALESTER REGIONAL HEALTH CENTER
Phone: 918-421-6849 Fax: 877-249-1191

STAT REFERRAL

ACTH STIMULATION TEST ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ DOB: _____

HT: _____ in WT: _____ lbs 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:		

- 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

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STAT REFERRAL

LEQVIO ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ DOB: _____

HT: _____ in WT: _____ lbs 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 MEDIPOINT PIV PICC LINE OTHER: _____

PRESCRIPTION ORDERS

- a) ALL MEDIPOINTS / 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

- 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 \geq 190MG/DL (\geq 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 \geq 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 \geq 8 CONTINUOUS WEEKS? YES NO
- 7) 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
- 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

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Phone: 918-421-6849 Fax: 877-249-1191

STAT REFERRAL

PORT DEACCESS ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ DOB: _____

HT: _____ in WT: _____ lbs 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 MEDIPOINT PIV PICC LINE OTHER: _____

SELECT	WORK FLOW	INSTRUCTIONS
<input type="checkbox"/>	PUMP REMOVAL AND PORT FLUSH	DISCONNECT CHEMOTHERAPY PUMP AND GIVE TO PATIENT FLUSH PORT WITH 10 mL OF NS AND 500 units OF HEPARIN REMOVE HUBER NEEDLE
<input type="checkbox"/>	OTHER:	

ADDITIONAL NOTES:

Physician's Signature _____ Time _____ Date _____

**Signature Must Be Clear and Legible*

Cosignature (If Required) _____ Time _____ Date _____

**Signature Must Be Clear and Legible*

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STAT REFERRAL

SPRAVATO ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ DOB: _____

HT: _____ in WT: _____ lbs 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

Depression Severity Score: _____ Date: _____

Rating Scale Used: _____

(e.g., Beck Depression Inventory [BDI], Hamilton Depression Rating Scale [HDRS], Montgomery-Asberg Depression Rating Scale [MADRS], etc.)

PRESCRIPTION ORDERS

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY	DURATION
<input type="checkbox"/>	SPRAVATO INDUCTION DOSE(S)	56 mg	NASAL SPRAY	TWICE EVERY WEEK (WEEKS 1-4)	4 WEEKS
<input type="checkbox"/>	SPRAVATO INDUCTION DOSE(S)	84 mg	NASAL SPRAY	TWICE EVERY WEEK (WEEKS 1-4)	4 WEEKS
<input type="checkbox"/>	SPRAVATO MAINTENANCE DOSE(S)	56 mg	NASAL SPRAY	ONCE EVERY WEEK (WEEKS 5-8)	4 WEEKS
<input type="checkbox"/>	SPRAVATO MAINTENANCE DOSE(S)	84 mg	NASAL SPRAY	ONCE EVERY WEEK (WEEKS 5-8)	4 WEEKS
<input type="checkbox"/>	SPRAVATO MAINTENANCE DOSE(S)	56 mg	NASAL SPRAY	ONCE EVERY 2 WEEKS (WEEKS 9 AND AFTER)	
<input type="checkbox"/>	SPRAVATO MAINTENANCE DOSE(S)	84 mg	NASAL SPRAY	ONCE EVERY 2 WEEKS (WEEKS 9 AND AFTER)	
<input type="checkbox"/>	SPRAVATO MAINTENANCE DOSE(S)	56 mg	NASAL SPRAY	ONCE EVERY WEEK (WEEKS 9 AND AFTER)	
<input type="checkbox"/>	SPRAVATO MAINTENANCE DOSE(S)	84 mg	NASAL SPRAY	ONCE EVERY WEEK (WEEKS 9 AND AFTER)	

SUPPORTING DOCUMENTATION FOR PATIENTS RECEIVING SPRAVATO:

1) **Treatment-Resistant Depression (TRD)**

- Patients have a confirmed diagnosis of severe major depressive disorder (single or recurrent episode), documented by standardized rating scales that reliably measure depressive symptoms.
- Patients have experienced inadequate response during the current depressive episode with two antidepressants from at least two different classes with different mechanisms of action at the maximally tolerated labeled dose, each used for at least 8 weeks within the past 5 years.
- Patients have experienced an inadequate response with an adequate trial of augmentation therapy for at least 8 weeks within the past 5 years or evidenced based psychotherapy.

2) **Major Depressive Disorder (MDD) with acute suicidal ideation or behavior**

- Patients have major depressive disorder with current suicidal ideation with intent.
- The prescriber must present in the clinical documentation that, in the absence of the requested drug, within the next 24 to 48 hours the patient will require confinement in an acute care psychiatric institution; and the requested medication will be used in combination with an oral antidepressant.

*Provider must enroll patient in the SPRAVATO REMS Program and provide enrollment confirmation documentation.

*This medication must be prescribed by or in consultation with a psychiatrist

*Spravato nasal spray is considered an exclusion for members with moderate or severe substance or alcohol use disorder that is not currently being treated or medically managed.

*Augmentation therapy is defined as: two antidepressants with different mechanisms of action used concomitantly, an antidepressant and a second-generation antipsychotic used concomitantly, an antidepressant and lithium used concomitantly, or an antidepressant and thyroid hormone used concomitantly.

Physician's Signature _____ Time _____ Date _____

*Signature Must Be Clear and Legible

Cosignature (If Required) _____ Time _____ Date _____

*Signature Must Be Clear and Legible

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