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

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Partial Medication Listing

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

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McAlester Regional Outpatient Infusion Center
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Phone: 918-421-6849 Fax: 877-249-1191

☐ **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** ☐ **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
☐		FRESH FROZEN PLASMA
☐		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:	

PREMEDS

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY
☐	NONE	NA	NA	NA
☐	BENADRYL	☐ 25 mg ☐ 50 mg	☐ PO ☐ IV	☐ ONCE ☐ PRN
☐	ACETAMINOPHEN	☐ 500 mg ☐ 650 mg	PO	☐ ONCE ☐ PRN
☐	FUROSEMIDE	☐ 20 mg ☐ 40 mg ☐ 80 mg	IV	☐ ONCE ☐ PRN
☐	HEPARIN FLUSH	500 units	IV	☐ ONCE ☐ PRN
☐	SODIUM CHLORIDE 0.9%	100 mL (for IV Flush)	IV	☐ ONCE ☐ PRN
☐	OXYGEN			
☐	OTHER:			
☐	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.

McAlester Regional Outpatient Infusion Center
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☐ **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 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

MEDICATION SUBSTITUTION MAY APPLY PER HOSPITAL PROTOCOL AND PAYOR PREFERENCE

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY	DURATION
☐	FERAHEME (Preferred)	510 mg	IV	ONCE, THEN REPEAT 3 – 8 DAYS LATER	2 DOSES
☐	VENOFER	____mg	IV		
☐	VENOFER	200 mg	IV	ONCE EVERY WEEK	5 DOSES
☐	FERRLECIT	125 mg	IV		
☐	FERRLECIT	250 mg	IV		
☐	MONOFERRIC	____mg	IV		
☐	MONOFERRIC	1000 mg	IV	ONCE	1 DOSE
☐	INJECTAFER	750 mg	IV	ONCE EVERY WEEK	2 WEEKS
☐	OTHER:				

PREMEDS

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY
☐	NONE	NA	NA	NA
☐	BENADRYL	50 mg	IV	☐ ONCE ☐ PRN
☐	ACETAMINOPHEN	☐ 500 mg ☐ 650 mg	PO	☐ ONCE ☐ PRN
☐	EPINEPHRINE	0.3mg / 0.3mL	IM	☐ ONCE ☐ PRN
☐	SOLU-MEDROL	125 mg	IV	☐ ONCE ☐ PRN
☐	OXYGEN			
☐	OTHER:			

LABS

SELECT	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:		

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**

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 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

TREATMENT	mL TO REMOVE (+/- 50 mL)	PARAMATERS	FREQUENCY	DURATION
THERAPEUTIC PHLEBOTOMY		HOLD if ≤_____	☐ 1 x ONLY ☐ WEEKLY ☐ MONTHLY ☐ OTHER:	

LABS

SELECT	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*

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☐ **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** ☐ **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
d) RENFLEXIS DOSING WILL BE ROUNDED TO THE NEAREST 100MG VIAL

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	FREQUENCY
☐	NONE	NA	NA	NA
☐	BENADRYL	☐ 25 mg ☐ 50 mg	☐ PO ☐ IV	☐ ONCE ☐ PRN
☐	ACETAMINOPHEN	☐ 500 mg ☐ 650 mg	PO	☐ ONCE ☐ PRN
☐	SOLU-MEDROL	☐ 40 mg ☐ 125 mg	IV	☐ ONCE ☐ PRN
☐	OXYGEN			
☐	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	
☐	ALT	☐ PRIOR ☐ POST	
☐	AST	☐ PRIOR ☐ POST	
☐	LIVER PANEL	☐ PRIOR ☐ POST	
☐	VECTRA	☐ 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*

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☐ **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** ☐ **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	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*

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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** ☐ **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	3.) ☐ RALLY PACK / BANANA BAG
☐ 500 mL, IV x_____	☐ 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**
☐ 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	RATE
☐ BOLUS - GIVEN OVER 1 HOUR	☐ BOLUS - GIVEN OVER 1 HOUR	☐ 500 mL/hour
☐ Over 2 hours @_____ mL/hour	☐ Over 2 hours @_____mL/hour	☐ Other:_____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	LAB REQUESTED	WHEN
☐	NONE	NONE
☐	CBC w/ Diff	☐ PRIOR ☐ POST
☐	BMP	☐ PRIOR ☐ POST
☐	CMP	☐ PRIOR ☐ POST
☐	BUN/CREATININE	☐ 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*

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☐ **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** ☐ **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	ONCE EVERY 4 WEEKS	12 MONTHS
☐	OCREVUS LOADING DOSES	IV	300 mg AT 0, 2 WEEKS, THEN 600 mg ONCE EVERY 6 MONTHS	
☐	OCREVUS 600 mg MAINTENANCE DOSES	IV	ONCE EVERY 6 MONTHS	
☐	SOLU-MEDROL ☐ 500 mg ☐ 1000 mg	IV	DAILY	☐ 3 DAYS ☐ 5 DAYS

PREMEDS

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY
☐	BENADRYL	☐ 25 mg ☐ 50 mg	☐ PO ☐ IV	☐ ONCE ☐ PRN
☐	ACETAMINOPHEN	☐ 500 mg ☐ 650 mg	PO	☐ ONCE ☐ PRN
☐	SOLU-MEDROL	☐ 40 mg ☐ 125 mg	IV	☐ ONCE ☐ PRN
☐	FAMOTIDINE	☐ 20 mg ☐ 40 mg	☐ PO ☐ IV	☐ ONCE ☐ PRN
☐	OXYGEN			
☐	OTHER:			
☐	OTHER:			

LABS

SELECT	LAB REQUESTED	WHEN	FREQUENCY
☐	BMP	☐ PRIOR ☐ POST	
☐	CMP	☐ PRIOR ☐ POST	
☐	BUN/CREATININE	☐ PRIOR ☐ POST	
☐	JCV ANTIBODY (Patients taking Tysabri)	☐ 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.

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☐ **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 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
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
☐	_____mg / kg	IV	TITRATE PER PROTOCOL		
☐	Flat Dose:_____gm	IV	TITRATE PER PROTOCOL		

PREMEDS

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY
☐	BENADRYL	☐ 25 mg ☐ 50 mg	☐ PO ☐ IV	☐ ONCE ☐ PRN
☐	ACETAMINOPHEN	☐ 500 mg ☐ 650 mg	PO	☐ ONCE ☐ PRN
☐	SOLUMEDROL	☐ 40 mg ☐ 125 mg	IV	☐ ONCE ☐ PRN
☐	FAMOTIDINE	☐ 20 mg ☐ 40 mg	☐ PO ☐ IV	☐ ONCE ☐ PRN
☐	OTHER:			

LABS

SELECT	LAB REQUESTED	WHEN	FREQUENCY
☐	BMP	☐ PRIOR ☐ POST	
☐	CMP	☐ PRIOR ☐ POST	
☐	BUN/CREATININE	☐ PRIOR ☐ POST	
☐	OTHER:		
☐	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, 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**

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
☐	**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**
☐	***SELECT ONE:*** ☐ **PROLIA** ☐ **CONEXXENCE** ☐ **JUBBONTI** ☐ **STOBOCLO (DENOSUMAB)** BUN, CREAT, CALCIUM LEVEL WITHIN 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 WITHIN 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**

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*

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Phone: 918-421-6849 Fax: 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 ≥ to _12 g/dL__

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY	DURATION
☐	**RETACRIT ESRD *(Patients on Dialysis)***				
☐	**RETACRIT NON ESRD**				
☐	**ZARXIO (Granix Substitute)**				
☐	**ARANESP**				
☐	**NEULASTA**				
☐	**OTHER:**				

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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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
☐	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	MEDICATION	DOSE	ROUTE	FREQUENCY
☐	NONE	NA	NA	NA
☐	BENADRYL	☐ 25 mg ☐ 50 mg	☐ PO ☐ IV	☐ ONCE ☐ PRN
☐	ACETAMINOPHEN	☐ 500 mg ☐ 650 mg	PO	☐ ONCE ☐ PRN
☐	OXYGEN			
☐	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	
☐	OTHER:		

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**

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 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

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

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	
☐	INFLECTRA LOADING DOSE(S)	_____mg / kg	IV	0, 2, 6 WEEKS, THEN ONCE EVERY_____WEEKS	
☐	INFLECTRA 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	FREQUENCY
☐	NONE	NA	NA	
☐	BENADRYL	☐ 25 mg ☐ 50 mg	☐ PO ☐ IV	☐ ONCE ☐ PRN
☐	ACETAMINOPHEN	☐ 500 mg ☐ 650 mg	PO	☐ ONCE ☐ PRN
☐	SOLU-MEDROL	☐ 40 mg ☐ 125 mg	IV	☐ ONCE ☐ PRN
☐	ONDANSETRON	4 mg	☐ PO ☐ IV	☐ ONCE ☐ PRN
☐	FAMOTIDINE	☐ 20 mg ☐ 40 mg	☐ PO ☐ IV	☐ ONCE ☐ PRN
☐	OXYGEN			
☐	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	
☐	OTHER:		

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

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

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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** ☐ **MEDIPORT** ☐ **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
☐	BENADRYL				
☐	COMPAZINE				
☐	VALPROATE SODIUM	☐ 500 mg ☐ 1000mg	IV		
☐	DIHYDROERGOTAMINE	1 mg	☐ IM ☐ IV ☐ SQ		
☐	CEREBYX				
☐	KEPPRA				
☐	KETOROLAC				
☐	METHYLPREDNISOLONE				
☐	METOCLOPRAMIDE				
☐	ORPHENADRINE				
☐	PROMETHAZINE	☐ 25 mg ☐ 50 mg	IM		
☐	VYEPTI	100 mg	IV	ONCE EVERY 3 MONTHS	
☐	VYEPTI	300 mg	IV	ONCE EVERY 3 MONTHS	
☐	0.9% NS				

PREMEDS

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY
☐	NONE	NA	NA	
☐	BENADRYL	☐ 25 mg ☐ 50 mg	☐ PO ☐ IV	☐ ONCE ☐ PRN
☐	ACETAMINOPHEN	☐ 500 mg ☐ 650 mg	PO	☐ ONCE ☐ PRN
☐	ONDANSETRON	4 mg	☐ PO ☐ IV	☐ ONCE ☐ PRN
☐	OXYGEN			☐ ONCE ☐ PRN
☐	ZOFRAN		IV	☐ ONCE ☐ PRN
☐	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	
☐	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**

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 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)	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		
☐			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:**		
☐	**Other:**		
☐	**Other:**		
☐	**Other:**		
☐	**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*

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Phone: 918-421-6849 Fax: 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** ☐ **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

□ 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*

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

☐ **STAT REFERRAL**

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** ☐ **MEDIPORT** ☐ **PIV** ☐ **PICC LINE** ☐ **OTHER:**_____

c) ALL MEDIPORTS / 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
← 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

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

PRESCRIPTION ORDERS

SELECT	DRUG	TITRATED DOSING	ROUTE	TITRATED SCHEDULE	DURATION
☐	**Kisunla**	**350 mg**	**IV Over At Least 30 Minutes**	**Infusion 1**	**1 time**
☐	**Kisunla**	**700 mg**	**IV Over At Least 30 Minutes**	**Infusion 2 (4 weeks after infusion 1)**	**1 time**
☐	**Kisunla**	**1050 mg**	**IV Over At Least 30 Minutes**	**Infusion 3 (4 weeks after infusion 2)**	**1 time**
☐	**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*

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**

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

LABS

SELECT	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*

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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** ☐ **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	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*

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☐ **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** ☐ **MEDIPORT** ☐ **PIV** ☐ **PICC LINE** ☐ **OTHER:**_____

SELECT	WORK FLOW	INSTRUCTIONS
☐	**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**
☐	**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
☐	SPRAVATO INDUCTION DOSE(S)	56 mg	NASAL SPRAY	TWICE EVERY WEEK (WEEKS 1-4)	4 WEEKS
☐	SPRAVATO INDUCTION DOSE(S)	84 mg	NASAL SPRAY	TWICE EVERY WEEK (WEEKS 1-4)	4 WEEKS
☐	SPRAVATO MAINTENANCE DOSE(S)	56 mg	NASAL SPRAY	ONCE EVERY WEEK (WEEKS 5-8)	4 WEEKS
☐	SPRAVATO MAINTENANCE DOSE(S)	84 mg	NASAL SPRAY	ONCE EVERY WEEK (WEEKS 5-8)	4 WEEKS
☐	SPRAVATO MAINTENANCE DOSE(S)	56 mg	NASAL SPRAY	ONCE EVERY 2 WEEKS (WEEKS 9 AND AFTER)	
☐	SPRAVATO MAINTENANCE DOSE(S)	84 mg	NASAL SPRAY	ONCE EVERY 2 WEEKS (WEEKS 9 AND AFTER)	
☐	SPRAVATO MAINTENANCE DOSE(S)	56 mg	NASAL SPRAY	ONCE EVERY WEEK (WEEKS 9 AND AFTER)	
☐	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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