

Patient Information

Patient Name: _____ Birthdate: _____ Sex: ☐ Male ☐ Female Height: _____ Weight: _____ ☐ lb ☐ kg
 Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____
 Address: _____ City: _____ State: _____ Zip: _____

Insurance Information: Please fax FRONT and BACK of insurance card.

Plan Name: _____ Plan Phone: _____
 ID #: _____ Group #: _____ RxBIN: _____ RxPCN: _____

Prescriber Information

Prescriber Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____
 Address: _____ Phone: (_____) _____ - _____ Fax: (_____) _____ - _____
 City: _____ State: _____ Zip: _____ Key Contact: _____ Phone: (_____) _____ - _____

Diagnosis/Clinical Information | Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization

☐ _____ (ICD-10) _____ (description) ☐ _____ (ICD-10) _____ (description)

Orders

Is this a first dose? ☐ Yes ☐ No (If yes, select site) Site: ☐ Home ☐ Infusion Center ☐ No preference (If no preference, will follow policy/protocol)

Med Name: _____ Dose: _____
 Route: ☐ IV ☐ Subcutaneous (SC)
 Infuse over: _____
☐ Initiate at: _____
☐ Maintenance dose: _____
☐ Other: _____
 Estimated Length of Therapy: _____
☐ Other Orders: _____

Refills
☐ Qty: _____

☐ Start peripheral IV, remove after treatment, flush with 10ml NS before and after treatment and PRN.
☐ For Port-a-cath: access before treatment, de-access after treatment, for consecutive treatment days, may leave accessed; flush line with 10ml NS pre and post-infusion and PRN, lock with 3-5ml 100u/ml heparin, weekly dressing and needle change.
☐ For midline/PICC/CVC: flush before and after infusion, daily and PRN with 10ml NS and 3-5ml 100u/ml heparin, weekly dressing change and PRN if lose or soiled.
☐ Activase (Cathflo) 2mg/2ml per lumen PRN to restore blood return, catheter patency.
☐ For SC infusion assess for optimal site, access site(s) and administer per instructions, remove access after treatment.

Pre-Medications as needed: Administer 30 minutes before

Medication	Route	Dose/Strength	Medication	Route	Dose/Strength
☐ Famotidine	☐ PO ☐ IV	20 mg	☐ Dexamethasone	IV	☐ 10 mg ☐ 20 mg
☐ Acetaminophen	☐ IV ☐ PO	☐ 500 mg ☐ 650 mg ☐ 1000 mg	☐ Loratadine	PO	10 mg
☐ Diphenhydramine	☐ PO ☐ IV	☐ 25 mg ☐ 50 mg	☐ Cetirizine HCL	PO	10 mg
☐ Zofran	☐ IV ☐ ODT	4 mg	☐ Methylprednisolone	IV	
☐ Other: _____					

Medications to be used as needed: (please strike through if not required)
 Diphenhydramine 25 mg by mouth every 4-6 hours as needed for mild infusion reactions, may increase to 50 mg for moderate to severe; maximum of 4 doses per day (contraindicated in patients with myasthenia gravis). Acetaminophen 500 mg by mouth every 4-6 hours as needed for fever, headache or chills; maximum of 4 doses per day.

Anaphylaxis Medications	Anaphylaxis Medication Administration Orders
☐ Epinephrine 1mg/ml (1:1000) ampules x 3	☐ Epinephrine (1:1000) amp Dose: 0.3mg/0.3ml IM.
☐ Diphenhydramine/Benadryl 50mg/vial x1	May repeat in 5 minutes PRN x 2 **NOT FOR IV USE
☐ Sodium Chloride 0.9% 500ml x 1	☐ Diphenhydramine Dose: 50mg IV or IM x 1, IV push max rate 25mg/min
☐ _____	

Anaphylaxis and Nursing Protocol

- Stop infusion administration immediately, maintain IV access. Administer first dose Epinephrine.
- Activate EMS, call 911, initiate CPR/BLS, remain with patient till EMS arrives
- Start Sodium Chloride 0.9% 500ml and begin infusion at 125ml/hr for normotensive, if SBP <90mmHg or 30% decrease from baseline administer at 500ml/hr or as ordered by physician or emergency personnel.
- Administer additional anaphylaxis medications as ordered, epinephrine and diphenhydramine. Monitor patient's vital signs.
- Notify Physician and Pharmacist.

*Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

☐ Product Substitution Permitted ☐ Dispense as Written

STAMP SIGNATURE NOT ALLOWED Prescriber's Signature: _____ Date: _____