



Order Form

Please include recent labs and last two office visit notes

Please fax to 907-746-7798 - Clinic Phone Number: 907-746-7771

PATIENT INFORMATION

| | | |
|---|---|--------------------------------|
| Name: | DOB: | |
| Home phone: | Other phone: | |
| Email: | | |
| Social Security #: | Allergies: | |
| Gender: <input type="checkbox"/> M <input type="checkbox"/> F | Weight: | |
| Patient Status: <input type="checkbox"/> New to therapy | <input type="checkbox"/> Continuing therapy | Next due date (if applicable): |

PHYSICIAN INFORMATION

| | | |
|-------------------|-------------|-------|
| Physician's Name: | NPI#: | |
| License #: | TIN#: | DEA#: |
| Address: | | |
| City: | State: | Zip: |
| Office phone: | Email: | |
| Office contact: | Office fax: | |

DIAGNOSIS INFORMATION

| | |
|------------------|--------------------|
| Diagnosis: | ICD-10: |
| Other (specify): | Year of diagnosis: |

INSURANCE INFORMATION

Please submit copies of the front and back of primary and secondary insurance cards with this referral.

Primary Insurance: ID# Secondary Insurance: ID#

PRESCRIPTION INFORMATION (requires new order every 12 months)

Medication may be substituted with payer-preferred brand, generic, or biosimilar equivalent per authorization and institutional formulary

Medication:

Initial Maintenance
 KVO: NS D5W

PRE-MEDICATIONS:

N/A

Acetaminophen: 500mg 650mg 1000mg
 Loratadine (Claritin): 10mg PO
 Diphenhydramine: 25mg 50mg PO IV
 Dexamethasone: 5mg 10mg 20 mg IV
 Famotidine: 20 mg IV

POST-MEDICATIONS

Acetaminophen: 500mg 650mg 1000mg
 Other orders:

Vital signs per clinic protocol

Infusion reaction/Hydration Management per clinic protocol

Signature (required)

PHYSICIAN SIGNATURE

DATE