

Infusion Services Referral Form

Referral Line Phone 615-986-4380

Fax 615-986-4381

PATIENT INFORMATION

Patient Name: _____ Date of Birth: ____/____/____

Height: _____ Weight: _____ Allergies: _____

Date of Referral: ____/____/____ ICD-10 Code: _____

Patient Status: ☐ New Referral ☐ Updated Orders ☐ Order Renewal

Preferred Clinic Location: _____

PROVIDER INFORMATION

Referring Provider: _____ Specialty: _____

Referring Practice Name: _____

Phone: _____ Fax: _____

REQUIRED DOCUMENTATION

☐ Patient Demographics ☐ Patient Insurance ☐ Diagnostic testing

☐ Lab results within 12 months (CBC required)

☐ Office visit note within 12 months including: ☐ Recent H&P ☐ Clinical notation of any tried and failed therapies

*Referring provider responsible for providing records, including labs, annually

PHYSICIAN ORDER

Belimumab (Benlysta)

ADMINISTRATION

Belimumab (Benlysta) in 250mL NS

Route: Intravenous infusion

Dose: ☐ 10mg/kg

Frequency: ☐ Initiation: q14d x 3 doses

☐ Maintenance: q28d

Rate: 60min infusion with NS flush to follow

Observation: 60min post infusion

Comments: _____

*TN Oncology will substitute requested drug with a biosimilar or generic if required by the patient's insurance, unless referring provider indicates no substitutions allowed

PREMEDICATION

- ☐ No premedication
- ☐ Dexamethasone ☐ 10mg IV
- ☐ Diphenhydramine ☐ 25mg ☐ 50mg ☐ PO / ☐ IV
- ☐ Acetaminophen ☐ 325mg ☐ 650mg PO ☐ 1000mg PO
- ☐ Methylprednisolone (Solu-Medrol) ☐ 125mg IV
- ☐ Other: _____

*If section left blank, TNONC provider will defer to current TNONC premedication guidelines

*In the event of infusion reaction, Nursing care will defer to TNONC Adverse Drug Reaction Protocol

LAB ORDERS

- ☐ CBC ☐ Prior to each treatment ☐ Other: _____
- ☐ CMP ☐ Prior to each treatment ☐ Other: _____
- ☐ CRP ☐ Prior to each treatment ☐ Other: _____
- ☐ Other: _____

*If section left blank, TNONC provider will defer to current TNONC monitoring parameter guidelines

PHYSICIAN SIGNATURE

Provider Name (Print)

Provider Signature

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REQUIRED DOCUMENTATION

☐ Patient Demographics ☐ Patient Insurance ☐ Diagnostic testing

☐ Lab results within 12 months (CBC, LFTs, TB gold required)

☐ Office visit note within 12 months including: ☐ Recent H&P ☐ Clinical notation of any tried and failed therapies

*Referring provider responsible for providing records, including labs, annually

PHYSICIAN ORDER

Vedolizumab (Entyvio)

ADMINISTRATION

Vedolizumab (Entyvio) in 250mL NS

Route: Intravenous infusion

Dose: ☐ 300mg

Frequency: ☐ Initiation: week 0, 2, 6

☐ Maintenance: q8wk or ☐ Other: _____

Rate: 30min infusion with 30mL NS flush to follow

Observation: None

Comments: _____

*TN Oncology will substitute requested drug with a biosimilar or generic if required by the patient's insurance, unless referring provider indicates no substitutions allowed

PREMEDICATION

- ☐ No premedication
- ☐ Dexamethasone ☐ 10mg IV
- ☐ Diphenhydramine ☐ 25mg ☐ 50mg ☐ PO / ☐ IV
- ☐ Acetaminophen ☐ 325mg ☐ 650mg PO
- ☐ Methylprednisolone (Solu-Medrol) ☐ 125mg IV
- ☐ Other: _____

*If section left blank, TNONC provider will defer to current TNONC premedication guidelines

*In the event of infusion reaction, Nursing care will defer to TNONC Adverse Drug Reaction Protocol

LAB ORDERS

- ☐ CBC ☐ Prior to each treatment ☐ Other: _____
- ☐ CMP ☐ Prior to each treatment ☐ Other: _____
- ☐ CRP ☐ Prior to each treatment ☐ Other: _____
- ☐ Other: _____

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REQUIRED DOCUMENTATION

☐ Patient Demographics ☐ Patient Insurance ☐ Diagnostic testing

☐ Lab results within 12 months (CBC, LFTs, TB gold, HIV, HBV, Hepatitis C required)

☐ Office visit note within 12 months including: ☐ Recent H&P ☐ Clinical notation of any tried and failed therapies

*Referring provider responsible for providing records, including labs, annually

PHYSICIAN ORDER

Infliximab (Avsola, Inflectra, Remicade, Renflexis)

ADMINISTRATION

Infliximab in 250mL NS

Route: Intravenous infusion

Dose: ☐ 3mg/kg ☐ 5mg/kg ☐ 7.5mg/kg ☐ 10mg/kg ☐ Other: _____

Frequency: ☐ Initiation: week 0, 2, 6, then q8wk

☐ Maintenance: q8wk or ☐ Other: _____

Rate: 2hr infusion with NS flush to follow

Observation: None

Comments: _____

*TN Oncology will substitute requested drug with a biosimilar or generic if required by the patient's insurance, unless referring provider indicates no substitutions allowed

PREMEDICATION

- ☐ No premedication
- ☐ Dexamethasone ☐ 10mg IV
- ☐ Diphenhydramine ☐ 25mg ☐ 50mg ☐ PO / ☐ IV
- ☐ Acetaminophen ☐ 325mg ☐ 650mg PO
- ☐ Methylprednisolone (Solu-Medrol) ☐ 125mg IV
- ☐ Other: _____

*If section left blank, TNONC provider will defer to current TNONC premedication guidelines

*In the event of infusion reaction, Nursing care will defer to TNONC Adverse Drug Reaction Protocol

LAB ORDERS

- ☐ CBC ☐ Prior to each treatment ☐ Other: _____
- ☐ CMP ☐ Prior to each treatment ☐ Other: _____
- ☐ CRP ☐ Prior to each treatment ☐ Other: _____
- ☐ Other: _____

*If section left blank, TNONC provider will defer to current TNONC monitoring parameter guidelines

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REQUIRED DOCUMENTATION

☐ Patient Demographics ☐ Patient Insurance ☐ Diagnostic testing

☐ Lab results within 12 months (CBC, Hepatitis B core & antigen required)

☐ Office visit note within 12 months including: ☐ Recent H&P ☐ Clinical notation of any tried and failed therapies

*Referring provider responsible for providing records, including labs, annually

PHYSICIAN ORDER

Ocrelizumab (Ocrevus)

ADMINISTRATION

Ocrelizumab (Ocrevus) in 250mL or 500mL NS

Route: Intravenous infusion

Dose/Frequency: Initiation ☐ 300mg Q14d x 2doses

Maintenance (6mo post initiation) ☐ 600mg Q6mo x _____ doses

Rate: Titrated per policy with NS flush to follow

Observation: 60min observation post infusion

Comments: _____

*TN Oncology will substitute requested drug with a biosimilar or generic if required by the patient's insurance, unless referring provider indicates no substitutions allowed

PREMEDICATION

- ☐ No premedication
- ☐ Dexamethasone ☐ 10mg IV
- ☐ Diphenhydramine ☐ 25mg ☐ 50mg ☐ PO / ☐ IV
- ☐ Acetaminophen ☐ 325mg ☐ 650mg PO
- ☐ Methylprednisolone (Solu-Medrol) ☐ 125mg IV
- ☐ Other: _____

*If section left blank, TNONC provider will defer to current TNONC premedication guidelines

*In the event of infusion reaction, Nursing care will defer to TNONC Adverse Drug Reaction Protocol

LAB ORDERS

- ☐ CBC ☐ Prior to each treatment ☐ Other: _____
- ☐ CMP ☐ Prior to each treatment ☐ Other: _____
- ☐ CRP ☐ Prior to each treatment ☐ Other: _____
- ☐ Other: _____

*If section left blank, TNONC provider will defer to current TNONC monitoring parameter guidelines

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Referring Practice Name: _____

Phone: _____ Fax: _____

REQUIRED DOCUMENTATION

☐ Patient Demographics ☐ Patient Insurance ☐ Diagnostic testing

☐ Lab results within 12 months (CBC, TB gold, HBV, Hepatitis C required)

☐ Office visit note within 12 months including: ☐ Recent H&P ☐ Clinical notation of any tried and failed therapies

*Referring provider responsible for providing records, including labs, annually

PHYSICIAN ORDER

Abatacept (Orencia)

ADMINISTRATION

Abatacept (Orencia) in 100mL NS

Route: Intravenous infusion

Dose: ☐ <60kg: 500mg ☐ 60-100kg: 750mg ☐ >100kg: 1,000mg ☐ Other: _____

Frequency: ☐ Initiation: week 0, 2, 4

☐ Maintenance: q4wk after initiation or ☐ Other: _____

Rate: 30min infusion with NS flush to follow

Observation: None

Comments: _____

*TN Oncology will substitute requested drug with a biosimilar or generic if required by the patient's insurance, unless referring provider indicates no substitutions allowed

PREMEDICATION

- ☐ No premedication
- ☐ Dexamethasone ☐ 10mg IV
- ☐ Diphenhydramine ☐ 25mg ☐ 50mg ☐ PO / ☐ IV
- ☐ Acetaminophen ☐ 325mg ☐ 650mg PO
- ☐ Methylprednisolone (Solu-Medrol) ☐ 125mg IV
- ☐ Other: _____

*If section left blank, TNONC provider will defer to current TNONC premedication guidelines

*In the event of infusion reaction, Nursing care will defer to TNONC Adverse Drug Reaction Protocol

LAB ORDERS

- ☐ CBC ☐ Prior to each treatment ☐ Other: _____
- ☐ CMP ☐ Prior to each treatment ☐ Other: _____
- ☐ CRP ☐ Prior to each treatment ☐ Other: _____
- ☐ Other: _____

*If section left blank, TNONC provider will defer to current TNONC monitoring parameter guidelines

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PROVIDER INFORMATION

Referring Provider: _____ Specialty: _____

Referring Practice Name: _____

Phone: _____ Fax: _____

REQUIRED DOCUMENTATION

☐ Patient Demographics ☐ Patient Insurance ☐ Diagnostic testing

☐ Lab results within 12 months (CBC w/ differential; Hepatitis B core & antigen required)

☐ Office visit note within 12 months including: ☐ Recent H&P ☐ Clinical notation of any tried and failed therapies

*Referring provider responsible for providing records, including labs, annually

PHYSICIAN ORDER

Rituximab (Riabni, Rituxan, Truxima, Riximyo, Ruxience)

ADMINISTRATION

Rituximab in NS or D5W solution at 2mg/mL concentration

Route: Intravenous infusion

Dose: ☐ _____ mg

Frequency: ☐ Q _____ days x _____ doses

Rate: Titrated per policy with NS/D5W flush to follow

(Max rate 400mg/hr; First infusion titrated at slower rate)

Observation: None

Comments: _____

*TN Oncology will substitute requested drug with a biosimilar or generic if required by the patient's insurance, unless referring provider indicates no substitutions allowed

PREMEDICATION

- ☐ No premedication
- ☐ Dexamethasone ☐ 10mg IV
- ☐ Diphenhydramine ☐ 25mg ☐ 50mg ☐ PO / ☐ IV
- ☐ Acetaminophen ☐ 325mg ☐ 650mg PO
- ☐ Methylprednisolone (Solu-Medrol) ☐ 125mg IV
- ☐ Other: _____

*If section left blank, TNONC provider will defer to current TNONC premedication guidelines

*In the event of infusion reaction, Nursing care will defer to TNONC Adverse Drug Reaction Protocol

LAB ORDERS

- ☐ CBC ☐ Prior to each treatment ☐ Other: _____
- ☐ CMP ☐ Prior to each treatment ☐ Other: _____
- ☐ CRP ☐ Prior to each treatment ☐ Other: _____
- ☐ Other: _____

*If section left blank, TNONC provider will defer to current TNONC monitoring parameter guidelines

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PROVIDER INFORMATION

Referring Provider: _____ Specialty: _____

Referring Practice Name: _____

Phone: _____ Fax: _____

REQUIRED DOCUMENTATION

☐ Patient Demographics ☐ Patient Insurance ☐ Diagnostic testing

☐ Lab results within 12 months (CBC, Hepatitis B panel, TB gold required)

☐ Office visit note within 12 months including: ☐ Recent H&P ☐ Clinical notation of any tried and failed therapies

*Referring provider responsible for providing records, including labs, annually

PHYSICIAN ORDER

Ustekinumab (Stelara)

ADMINISTRATION

Ustekinumab (Stelara) in 250mL NS

Route: Intravenous infusion

Dose: ☐ 55 kg or less: 260mg ☐ 55kg-85kg: 390mg ☐ 85kg or more: 520mg

Frequency: 1 dose

Rate: 60min infusion with NS flush to follow

Observation: None

Comments: _____

*TN Oncology will substitute requested drug with a biosimilar or generic if required by the patient's insurance, unless referring provider indicates no substitutions allowed

PREMEDICATION

- ☐ No premedication
- ☐ Dexamethasone ☐ 10mg IV
- ☐ Diphenhydramine ☐ 25mg ☐ 50mg ☐ PO / ☐ IV
- ☐ Acetaminophen ☐ 325mg ☐ 650mg PO ☐ 1000mg PO
- ☐ Methylprednisolone (Solu-Medrol) ☐ 125mg IV
- ☐ Other: _____

*If section left blank, TNONC provider will defer to current TNONC premedication guidelines

*In the event of infusion reaction, Nursing care will defer to TNONC Adverse Drug Reaction Protocol

LAB ORDERS

- ☐ CBC ☐ Prior to each treatment ☐ Other: _____
- ☐ CMP ☐ Prior to each treatment ☐ Other: _____
- ☐ CRP ☐ Prior to each treatment ☐ Other: _____
- ☐ Other: _____

*If section left blank, TNONC provider will defer to current TNONC monitoring parameter guidelines

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PROVIDER INFORMATION

Referring Provider: _____ Specialty: _____

Referring Practice Name: _____

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REQUIRED DOCUMENTATION

☐ Patient Demographics ☐ Patient Insurance ☐ Diagnostic testing (baseline brain MRI within 12 months required)

*Monitoring: brain MRI at 3-6mo, at 12mo, then annually

☐ Lab results within 12 months (CBC, LFTs, anti-JCV antibody required)

☐ Office visit note within 12 months including: ☐ Recent H&P ☐ Clinical notation of any tried and failed therapies

*Referring provider responsible for providing records, including labs, annually

PHYSICIAN ORDER

Natalizumab (Tysabri) *(REMS)

ADMINISTRATION

Natalizumab (Tysabri) in 100mL NS

Route: Intravenous infusion

Dose: ☐ 300mg

Frequency: q28d (Recommended to limit duration of therapy to 24mo unless benefit outweighs risks)

Rate: 60min infusion with NS flush to follow

Observation: 60min after infusion

Comments: _____

*TN Oncology will substitute requested drug with a biosimilar or generic if required by the patient's insurance, unless referring provider indicates no substitutions allowed

PREMEDICATION

- ☐ No premedication
- ☐ Dexamethasone ☐ 10mg IV
- ☐ Diphenhydramine ☐ 25mg ☐ 50mg ☐ PO / ☐ IV
- ☐ Acetaminophen ☐ 325mg ☐ 650mg PO ☐ 1000mg PO
- ☐ Methylprednisolone (Solu-Medrol) ☐ 125mg IV
- ☐ Other: _____

*If section left blank, TNONC provider will defer to current TNONC premedication guidelines

*In the event of infusion reaction, Nursing care will defer to TNONC Adverse Drug Reaction Protocol

LAB ORDERS

- ☐ CBC ☐ Prior to each treatment ☐ Other: _____
- ☐ CMP ☐ Prior to each treatment ☐ Other: _____
- ☐ CRP ☐ Prior to each treatment ☐ Other: _____
- ☐ Other: _____

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REQUIRED DOCUMENTATION

☐ Patient Demographics ☐ Patient Insurance ☐ Diagnostic testing

☐ Office visit note within 12 months including: ☐ Recent H&P ☐ Clinical notation of any tried and failed therapies

*Referring provider responsible for providing records, including labs, annually

PHYSICIAN ORDER

Eptinezumab (Vyepi)

ADMINISTRATION

Eptinezumab (Vyepi) in 100mL 0.9% NS

Route: Intravenous infusion

Dose: ☐ 100mg ☐ 300mg

Frequency: ☐ Q 3 months ☐ Other: _____

Rate: 30min infusion with 20mL NS flush to follow

Observation: None

Comments: _____

*TN Oncology will substitute requested drug with a biosimilar or generic if required by the patient's insurance, unless referring provider indicates no substitutions allowed

PREMEDICATION

- ☐ No premedication
- ☐ Dexamethasone ☐ 10mg IV
- ☐ Diphenhydramine ☐ 25mg ☐ 50mg ☐ PO / ☐ IV
- ☐ Acetaminophen ☐ 325mg ☐ 650mg PO
- ☐ Methylprednisolone (Solu-Medrol) ☐ 125mg IV
- ☐ Other: _____

*If section left blank, TNONC provider will defer to current TNONC premedication guidelines

*In the event of infusion reaction, Nursing care will defer to TNONC Adverse Drug Reaction Protocol

LAB ORDERS

- ☐ CBC ☐ Prior to each treatment ☐ Other: _____
- ☐ CMP ☐ Prior to each treatment ☐ Other: _____
- ☐ CRP ☐ Prior to each treatment ☐ Other: _____
- ☐ Other: _____

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