INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Tocilizumab *Actemra & biosimilars*

☐ Tyenne (tocilizumab-aazg) ☐ Actemra (tocilizumab) ☐ Tofidence (tocilizumab-bavi)
☐ Dispense as written (DAW) Will substitute for biosimilar or reference product based on insurance and availability unless DAW is checked.

PATIENT INFORMATION

Patient name _____ DOB _____
Mobile number _____ Patient weight _____ kg
Allergies _____
☐ Patient has known difficult venous access. Comments: _____
☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Rheumatoid Arthritis, ICD 10: M05. or M06.
☐ Giant Cell Arteritis, ICD 10: M31.
☐ Systemic Juvenile Idiopathic Arthritis (SJIA), ICD 10: M08.2
☐ Polyarticular Juvenile Idiopathic Arthritis (PJIA), ICD 10: M08.
☐ Cytokine Release Syndrome (CRS), ICD 10: D89.
☐ SSc-ILD, ICD 10: M34.81 (Actemra only)
☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____
Signature _____ Date _____
Contact name _____ Phone _____ Fax _____
Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Negative TB screen
☐ Demographics
☐ CBC with differential
☐ Labs and tests supporting diagnosis
☐ Liver function test
☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO
☐ Diphenhydramine (Benadryl) 25 mg PO
☐ Famotidine 20 mg IV
☐ Cetirizine (Zyrtec) 10 mg PO
☐ Methylprednisolone (Solu-Medrol) 125 mg IVP
☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Tocilizumab	☐ 4 mg/kg ☐ 6 mg/kg ☐ 8 mg/kg ☐ 10 mg/kg ☐ 12 mg/kg	IV	☐ Every 2 weeks ☐ Every 4 weeks ☐ Other: _____

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Alpha1-Proteinase Inhibitor *(human)*

☐ Glassia ☐ Prolastin-C Liquid ☐ Zemaira
☐ Dispense as written (DAW) Will substitute for biosimilar or reference product based on insurance and availability unless DAW is checked.

PATIENT INFORMATION

Patient name _____ DOB _____
Mobile number _____ Patient weight _____ kg
Allergies _____
☐ Patient has known difficult venous access. Comments: _____
☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Emphysema due to severe hereditary deficiency of Alpha1-PI (alpha1-antitrypsin deficiency), ICD 10: E88.01
☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____
Signature _____ Date _____
Contact name _____ Phone _____ Fax _____
Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☐ Methylprednisolone (Solu-Medrol) 125 mg IVP
☐ Diphenhydramine (Benadryl) 25 mg PO ☐ Cetirizine (Zyrtec) 10 mg PO
☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Alpha1-Proteinase Inhibitor (Human)	60 mg/kg body weight intravenously once per week	IV	Once per week

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Amvuttra *vutrisiran*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Wild-type transthyretin-mediated amyloidosis (ATTR), ICD 10: E85.82
☐ Polyneuropathy of hereditary transthyretin-mediated amyloidosis, ICD 10: E85.1
☐ Organ-limited amyloidosis, ICD 10: E85.4
☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☐ Methylprednisolone (Solu-Medrol) 125 mg IVP

☐ Diphenhydramine (Benadryl) 25 mg PO ☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Amvuttra	25mg	Subcutaneous inj.	q 3 months

LABS / SPECIAL INSTRUCTIONS

Patient is on dual therapy: ☐ Yes ☐ No

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Apretude *cabotegravir extended-release injectable suspension*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ PrEP to reduce the risk of sexually acquired HIV-1 infection in adults and adolescents weighing at least 35 kg who are at risk for HIV-1 acquisition, ICD 10: Z29.81

☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Individuals must have a negative HIV-1 test prior to initiating (with or without an oral lead-in with oral cabotegravir) for HIV-1 PrEP

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO

☐ Famotidine 20 mg IV

☐ Methylprednisolone (Solu-Medrol) 125 mg IVP

☐ Diphenhydramine (Benadryl) 25 mg PO

☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE / FREQUENCY	ROUTE
Apretude	600 mg injection given 1 month apart for 2 consecutive months on the last day of an oral lead-in (if used) or within 3 days, then continue with injections every 2 months thereafter	IM

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

Avastin *bevacizumab*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Metastatic colorectal cancer, ICD 10: C18. _____

☐ First-line non-squamous non-small cell lung cancer, ICD 10: C34. _____

☐ Recurrent glioblastoma, ICD 10: C71. _____

☐ Metastatic renal cell carcinoma, ICD 10: C64. _____

☐ Persistent, recurrent, or metastatic cervical cancer, ICD 10: C53. _____

☐ Stage III or IV epithelial ovarian, fallopian tube, or primary peritoneal cancer following initial surgical resection:

- ☐ C56. – Malignant neoplasm of ovary
- ☐ C57.0 – Malignant neoplasm of fallopian tube
- ☐ C48.2 – Malignant neoplasm of peritoneum, unspecified

☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☐ Methylprednisolone (Solu-Medrol) 125 mg IVP

☐ Diphenhydramine (Benadryl) 25 mg PO ☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

Order valid for 1 year from date of signature unless otherwise specified here: _____

Avastin *(continued)*

MEDICATION ORDER

MEDICATION	DOSE / FREQUENCY	ROUTE
Avastin	Metastatic colorectal cancer ☐ 5 mg/kg every 2 weeks with bolus-IFL ☐ 10 mg/kg every 2 weeks with FOLFOX4 ☐ 5 mg/kg every 2 weeks or 7.5 mg/kg every 3 weeks with fluoropyrimidine-irinotecan- or fluoropyrimidine-oxaliplatin-based chemotherapy after progression on a first-line bevacizumab product-containing regimen First-line non-squamous non-small cell lung cancer ☐ 15 mg/kg every 3 weeks with carboplatin and paclitaxel Recurrent glioblastoma ☐ 10 mg/kg every 2 weeks Metastatic renal cell carcinoma ☐ 10 mg/kg every 2 weeks with interferon alfa Persistent, recurrent, or metastatic cervical cancer ☐ 15 mg/kg every 3 weeks with paclitaxel and cisplatin, or paclitaxel and topotecan Stage III or IV epithelial ovarian, fallopian tube, or primary peritoneal cancer following initial surgical resection ☐ 15 mg/kg every 3 weeks with carboplatin and paclitaxel for up to 6 cycles, followed by 15 mg/kg every 3 weeks as a single agent, for a total of up to 22 cycles	Intravenous

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Benlysta *belimumab*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Systemic Lupus Erythematosus, ICD 10: M32.

☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☐ Methylprednisolone (Solu-Medrol) 125 mg IVP

☐ Diphenhydramine (Benadryl) 25 mg PO ☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Benlysta	10 mg/kg	IV	☐ Every 2 weeks x 3 doses, then every 4 weeks ☐ Every 4 weeks

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Briumvi *ublituximab-xiiy*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Relapsing-remitting multiple sclerosis (RRMS), ICD 10: G35.A
☐ Active secondary progressive multiple sclerosis (SPMS), ICD 10: G35.C1
☐ Clinically isolated syndrome (CIS), ICD 10: G36.9

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ HBsAg (Hepatitis B surface antigen) & Anti-HBc (Hepatitis B core antibody, total or IgG)
☐ Labs and tests supporting diagnosis
☐ Baseline liver function tests (LFTs) (ALT, AST, bilirubin, alkaline phosphatase) within 6 months
☐ Demographics
☐ Office/progress notes

PRE-MEDICATION

Recommendations per PI are pre-selected; these will be given unless otherwise specified.

☑ Acetaminophen (Tylenol) 500 mg PO
☑ Famotidine 20 mg IV
☑ Methylprednisolone (Solu-Medrol) 125 mg IVP
☑ Diphenhydramine (Benadryl) 25 mg PO
☐ Cetirizine (Zyrtec) 10 mg PO
☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE
Briumvi	☐ First infusion: 150 mg IV; second infusion: 450 mg IV two weeks after the first infusion, then 450 mg IV 24 weeks after the first infusion and every 24 weeks thereafter ☐ 450 mg IV every 24 weeks

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Cabenuva *cabotegravir extended-release; rilpivirine extended-release injectable suspension*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

HIV-1 infection in adults and adolescents 12 years and older weighing at least 35 kg, to replace the current antiretroviral regimen in those who are virologically suppressed (HIV-1 RNA <50 copies/mL) on a stable regimen with no history of treatment failure and no known or suspected resistance to cabotegravir or rilpivirine.

☐ Human immunodeficiency virus (HIV) disease, ICD 10: B20.

☐ Asymptomatic HIV infection status, ICD 10: Z21.

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☐ Methylprednisolone (Solu-Medrol) 125 mg IVP

☐ Diphenhydramine (Benadryl) 25 mg PO ☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Cabenuva	☐ Monthly dosing: Initiate injections of Cabenuva (600 mg of cabotegravir and 900 mg of rilpivirine) on the last day of current antiretroviral therapy or oral lead-in, and continue with injections of Cabenuva (400 mg of cabotegravir and 600 mg of rilpivirine) every month thereafter.	Gluteal IM injection	☐ Every month ☐ Every 2 months
	☐ Every-2-month dosing: Initiate injections of Cabenuva (600 mg of cabotegravir and 900 mg of rilpivirine) on the last day of current antiretroviral therapy or oral lead-in for 2 consecutive months, and continue with injections of Cabenuva every 2 months thereafter.		

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Cimzia *certolizumab*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Crohn's Disease, ICD 10: K50._____
☐ Rheumatoid Arthritis, ICD 10: M05._____ or M06._____
☐ Psoriatic Arthritis, ICD 10: L40._____
☐ Ankylosing Spondylitis, ICD 10: M45._____
☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Negative TB screen
☐ Labs and tests supporting diagnosis
☐ Negative Hepatitis
☐ Office/progress notes
☐ Demographics

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO
☐ Famotidine 20 mg IV
☐ Methylprednisolone (Solu-Medrol) 125 mg IVP
☐ Diphenhydramine (Benadryl) 25 mg PO
☐ Cetirizine (Zyrtec) 10 mg PO
☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Cimzia	☐ 100 mg ☐ 200 mg ☐ 400 mg ☐ Other: _____	Subcutaneous inj.	☐ Week 0, 2, 4 then maintenance of _____ mg every _____ weeks

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Cinqair *reslizumab*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Asthma, ICD 10: J45. _____

☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☐ Methylprednisolone (Solu-Medrol) 125 mg IVP

☐ Diphenhydramine (Benadryl) 25 mg PO ☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Cinqair	3 mg/kg	IV	Every 4 weeks

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Cosentyx *secukinumab*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Psoriatic Arthritis, ICD 10: L40.5
☐ Ankylosing Spondylitis, ICD 10: M45.9
☐ Non-radiographic Axial Spondyloarthritis, ICD 10: M45.A
☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Negative TB test
☐ Office/progress notes
☐ Demographics
☐ Labs and tests supporting diagnosis

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO
☐ Diphenhydramine (Benadryl) 25 mg PO
☐ Famotidine 20 mg IV
☐ Cetirizine (Zyrtec) 10 mg PO
☐ Methylprednisolone (Solu-Medrol) 125 mg IVP
☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Cosentyx	☐ With loading dose: 6 mg/kg at week 0, followed by 1.75 mg/kg every 4 weeks thereafter ☐ Without loading dose: 1.75 mg/kg *Loading dose optional *Max. maintenance dose 300 mg per infusion	IV	Every 4 weeks

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Elfabrio *pegunigalsidase alfa-iwxj*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Fabry disease, ICD 10: E75.21

☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☐ Methylprednisolone (Solu-Medrol) 125 mg IVP

☐ Diphenhydramine (Benadryl) 25 mg PO ☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Elfabrio	1 mg/kg every 2 weeks	IV	every 2 weeks

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Entyvio *vedolizumab*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Ulcerative Colitis, ICD 10: K51.
☐ Crohn's Disease, ICD 10: K50.
☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Negative TB results
☐ Office/progress notes
☐ Demographics
☐ Labs and tests supporting diagnosis

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO
☐ Famotidine 20 mg IV
☐ Methylprednisolone (Solu-Medrol) 125 mg IVP
☐ Diphenhydramine (Benadryl) 25 mg PO
☐ Cetirizine (Zyrtec) 10 mg PO
☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Entyvio	300 mg	IV	☐ Weeks 0, 2, 6, then every 8 weeks ☐ Every 8 weeks

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Evenity *romosozumab-aqqg*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Osteoporosis, with pathological fx, ICD 10: M80.

☐ Osteoporosis, without pathological fx, ICD 10: M81.

☐ If M80., location of previous fracture: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Normal calcium within 6 months of referral

☐ Labs and tests supporting diagnosis

☐ Demographics

☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO

☐ Famotidine 20 mg IV

☐ Methylprednisolone (Solu-Medrol) 125 mg IVP

☐ Diphenhydramine (Benadryl) 25 mg PO

☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Evenity	210 mg	Subcutaneous inj.	Every 4 weeks x 12 months

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Evkeeza *evinacumab-dgnb*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Homozygous Familial Hypercholesterolemia (HoFH), ICD 10: E78.010

☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☐ Methylprednisolone (Solu-Medrol) 125 mg IVP

☐ Diphenhydramine (Benadryl) 25 mg PO ☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Evkeeza	15 mg/kg	IV	Every 4 weeks

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Exdensur *depemokimab-ulaa*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Moderate or severe asthma, ICD 10: J45. _____

** Add-on maintenance treatment of severe asthma characterized by an eosinophilic phenotype in adult and pediatric patients aged 12 years and older, ICD 10: J82.83

☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☐ Methylprednisolone (Solu-Medrol) 125 mg IVP

☐ Diphenhydramine (Benadryl) 25 mg PO ☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Exdensur	100mg	Subcutaneous inj.	every 6 months

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Fabrazyme *agalsidease beta*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Fabry Disease, ICD 10: E75.21

☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☐ Methylprednisolone (Solu-Medrol) 125 mg IVP

☐ Diphenhydramine (Benadryl) 25 mg PO ☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Fabrazyme	1 mg/kg	IV	Every 2 weeks

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Fasenra *benralizumab*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Asthma, ICD 10: J45.

☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☐ Methylprednisolone (Solu-Medrol) 125 mg IVP

☐ Diphenhydramine (Benadryl) 25 mg PO ☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Fasenra	30 mg	Subcutaneous inj.	☐ Every 4 weeks x3, then every 8 weeks ☐ Every 8 weeks

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Faslodex *fulvestrant*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Hormone receptor (HR)-positive human epidermal growth factor receptor 2 (HER2)-negative advanced breast cancer in postmenopausal women not previously treated with endocrine therapy.

☐ HR-positive advanced breast cancer in postmenopausal women with disease progression following endocrine therapy.

☐ HR-positive, HER2-negative advanced or metastatic breast cancer in postmenopausal women in combination with ribociclib as initial endocrine based therapy or following disease progression on endocrine therapy.

☐ HR-positive, HER2-negative advanced or metastatic breast cancer in combination with palbociclib or abemaciclib in women with disease progression after endocrine therapy.

☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Demographics
☐ Office/progress notes
☐ Labs and tests supporting diagnosis
☐ Confirmed Hormone Receptor–Positive (HR+) Disease

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO
☐ Famotidine 20 mg IV
☐ Methylprednisolone (Solu-Medrol) 125 mg IVP
☐ Diphenhydramine (Benadryl) 25 mg PO
☐ Cetirizine (Zyrtec) 10 mg PO
☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE
Faslodex	500 mg administered intramuscularly into the gluteal area slowly over 1–2 minutes per injection, given as two 5 mL injections (250 mg in each gluteus maximus) on days 1, 15, 29, and once monthly thereafter.

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Gazyva *obinutuzumab*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Adults with active lupus nephritis (LN) who are receiving standard therapy, ICD 10: M32.14 _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ HBsAg (Hepatitis B surface antigen) & Anti-HBc (Hepatitis B core antibody, total or IgG)
☐ Demographics
☐ Labs and tests supporting diagnosis
☐ Office/progress notes

PRE-MEDICATION

Recommendations per PI are pre-selected; these will be given unless otherwise specified.

☑ Acetaminophen (Tylenol) 500 mg PO
☐ Famotidine 20 mg IV
☑ Methylprednisolone (Solu-Medrol) 125 mg IVP
☑ Diphenhydramine (Benadryl) 25 mg PO
☐ Cetirizine (Zyrtec) 10 mg PO
☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE / FREQUENCY	ROUTE
Gazyva	Active lupus nephritis: 1,000 mg at the initial infusion, then at weeks 2, 24, 26, and every 6 months thereafter	IV

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Givlaari *givosiran*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Adults with acute hepatic porphyria (AHP), ICD 10: E80.21

☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Liver function tests prior to starting treatment (within 6 months of referral)

☐ Demographics

☐ Labs and tests supporting diagnosis

☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO

☐ Famotidine 20 mg IV

☐ Methylprednisolone (Solu-Medrol) 125 mg IVP

☐ Diphenhydramine (Benadryl) 25 mg PO

☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Givlaari	2.5 mg/kg	Subcutaneous inj.ection	Monthly

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Herceptin *trastuzumab*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ HER2-overexpressing breast cancer, ICD 10: C50. _____

☐ HER2-overexpressing metastatic gastric or gastroesophageal junction adenocarcinoma, ICD 10: C16. _____

☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Demographics
☐ Confirmed HER2-Positive Status
☐ Labs and tests supporting diagnosis
☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO
☐ Famotidine 20 mg IV
☐ Methylprednisolone (Solu-Medrol) 125 mg IVP
☐ Diphenhydramine (Benadryl) 25 mg PO
☐ Cetirizine (Zyrtec) 10 mg PO
☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE / FREQUENCY	ROUTE
Herceptin	☐ 4 mg/kg, then 2 mg/kg every _____ weeks for _____ weeks ☐ 8 mg/kg, then 6 mg/kg every _____ weeks ☐ Other: _____	IV

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

HyQvia *immune globulin infusion 10% with recombinant human hyaluronidase*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Primary Immunodeficiency (PI), ICD 10: _____

☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP), ICD 10: _____

☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☐ Methylprednisolone (Solu-Medrol) 125 mg IVP

☐ Diphenhydramine (Benadryl) 25 mg PO ☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

☐ Ramp up & maintenance dose — patient is new to therapy; follow ramp-up scheduling per chart with the indicated dose, then continue to maintenance every _____ weeks

☐ Maintenance loading dose only — patient is currently on therapy and will continue as indicated every _____ weeks

Total dose: _____

TREATMENT INTERVAL	DOSING FREQUENCY Q4 WEEK	DOSING FREQUENCY Q3 WEEK
1st infusion (week 1)	Grams x 0.25	Grams x 0.33
2nd infusion (week 2)	Grams x 0.5	Grams x 0.67
3rd infusion (week 4)	Grams x 0.75	Administer total grams
4th infusion (week 7)	Administer total grams	n/a

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

IVIG *immune globulin intravenous*

- ☐ Asceniv
- ☐ Bivigam
- ☐ Gammagard Liquid 10%
- ☐ Gamunex-C 10%
- ☐ Gammaplex 5%
- ☐ Gammaplex 10%
- ☐ Octagam 5%
- ☐ Octagam 10%
- ☐ Privigen
- ☐ Panzyga
- ☐ Qivigy

☐ Dispense as written (DAW) Will substitute for biosimilar or reference product based on insurance and availability unless DAW is checked.

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

- ☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP), ICD 10: _____
- ☐ Primary Immunodeficiency, ICD 10: _____
- ☐ Myasthenia Gravis, ICD 10: _____
- ☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

- ☐ Demographics
- ☐ Labs and tests supporting diagnosis
- ☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

- ☐ Acetaminophen (Tylenol) 500 mg PO
- ☐ Famotidine 20 mg IV
- ☐ Methylprednisolone (Solu-Medrol) 125 mg IVP
- ☐ Diphenhydramine (Benadryl) 25 mg PO
- ☐ Cetirizine (Zyrtec) 10 mg PO
- ☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

Route: ☐ IV ☐ SubQ

Infuse Care will identify clinical appropriateness related to brand and infusion rates. May substitute based on the patient's insurance and product availability. All IVIG doses will be rounded to the nearest increment ending in 0 or 5 (e.g., 25 g, 30 g, 35 g) in accordance with institutional dosing guidelines.

	DOSE	UNIT	DURATION	FREQUENCY
Loading dose (as applicable)	_____	☐ mg/kg ☐ gm/kg ☐ grams	x _____ day(s) OR divided over _____ day(s)	☐ One time dose ☐ Other: _____ Give maintenance dose _____ days after loading dose
Maintenance dose	_____	☐ mg/kg ☐ gm/kg ☐ grams	x _____ day(s) OR divided over _____ day(s)	☐ Every _____ weeks x 1 year ☐ Other: _____

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Ilaris *canakinumab*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Periodic Fever Syndromes: Cryopyrin-Associated Periodic Syndromes (CAPS) in adults and children 4 years and older, including:
- ☐ Familial Cold Auto-inflammatory Syndrome (FCAS), ICD 10: M04.2
- ☐ Muckle-Wells Syndrome (MWS), ICD 10: M04.2
- ☐ Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS), adult and pediatric, ICD 10: M04.1
- ☐ Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD), adult and pediatric, ICD 10: M04.1
- ☐ Familial Mediterranean Fever (FMF), adult and pediatric, ICD 10: M04.1

☐ Active Still's Disease, including Adult-Onset Still's Disease (AOSD), ICD 10: M06.1, and Systemic Juvenile Idiopathic Arthritis (SJIA) in patients 2 years and older, ICD 10: M08.2

☐ Gout flares in adults in whom NSAIDs and colchicine are contraindicated, not tolerated, or inadequate, and in whom repeated courses of corticosteroids are not appropriate, ICD 10: M10. _____

☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Negative TB
☐ Office/progress notes
☐ Demographics
☐ Labs and tests supporting diagnosis

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO
☐ Famotidine 20 mg IV
☐ Methylprednisolone (Solu-Medrol) 125 mg IVP
☐ Diphenhydramine (Benadryl) 25 mg PO
☐ Cetirizine (Zyrtec) 10 mg PO
☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	CAPS / TRAPS, HIDS/MKD, FMF	STILL'S DISEASE / GOUT	ROUTE
Ilaris	CAPS ☐ >40 kg: 150 mg every 8 weeks ☐ 15–40 kg: 2 mg/kg every 8 weeks ☐ Other: _____ mg TRAPS, HIDS/MKD, and FMF ☐ >40 kg: 150 mg every 4 weeks ☐ >40 kg: 300 mg every 4 weeks (lack of clinical response) ☐ <40 kg: 2 mg/kg every 4 weeks ☐ <40 kg: 4 mg/kg every 4 weeks (lack of clinical response)	Still's Disease (AOSD and SJIA) ☐ >7.5 kg: 4 mg/kg every 4 weeks (max 300 mg) Gout flares ☐ 150 mg (12 weeks between doses if repeated)	Subcutaneous inj.

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Ilumya *tildrakizumab-asmn*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Psoriasis vulgaris, ICD 10: L40.

☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Negative TB ☐ Demographics ☐ Labs and tests supporting diagnosis

☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☐ Methylprednisolone (Solu-Medrol) 125 mg IVP

☐ Diphenhydramine (Benadryl) 25 mg PO ☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Ilumya	100 mg	Subcutaneous inj.	☐ Weeks 0, 4, then every 12 weeks ☐ Every 12 weeks

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Imaavy *nipocalimab-aahu*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Myasthenia gravis without (acute) exacerbation, ICD 10: G70.0

☐ Myasthenia gravis with (acute) exacerbation, ICD 10: G70.01

☐ Warm autoimmune hemolytic anemia (wAIHA) in adult and pediatric patients 12 years of age and older currently or previously treated with corticosteroids, ICD 10: D59.11

☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☐ Methylprednisolone (Solu-Medrol) 125 mg IVP

☐ Diphenhydramine (Benadryl) 25 mg PO ☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE / FREQUENCY	ROUTE
Imaavy	☐ Initial Dose: 30mg/kg, then 2 weeks later 15mg/kg and continue every 2 weeks ☐ 30mg/kg every 4 weeks	IV

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Isembyld *apitegromab-mstn*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Infantile spinal muscular atrophy, type I (Werdnig-Hoffman), ICD 10: G12.0

☐ Other inherited spinal muscular atrophy — includes adult SMA and SMA types II/III, ICD 10: G12.1

☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☐ Methylprednisolone (Solu-Medrol) 125 mg IVP

☐ Diphenhydramine (Benadryl) 25 mg PO ☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Isembyld	10 mg/kg	IV	Every 4 weeks

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Keytruda *pembrolizumab*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

Description: _____

ICD 10: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☐ Methylprednisolone (Solu-Medrol) 125 mg IVP

☐ Diphenhydramine (Benadryl) 25 mg PO ☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE
Keytruda	☐ 200 mg IV every 3 weeks ☐ 400 mg IV every 6 weeks ☐ 2 mg/kg (up to a max of 200 mg) IV

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Kisunla *donanemab-azbt*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Alzheimer's Disease, ICD 10: G30.9
☐ Alzheimer's Disease with Early Onset, ICD 10: G30.0
☐ Alzheimer's Disease with Late Onset, ICD 10: G30.1
☐ Other Alzheimer's Disease, ICD 10: G30.8

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Baseline MRI within 1 year, with repeat MRIs needed prior to the 2nd, 3rd, 4th, and 7th infusion
☐ Demographics
☐ Labs and tests supporting diagnosis
☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO
☐ Famotidine 20 mg IV
☐ Methylprednisolone (Solu-Medrol) 125 mg IVP
☐ Diphenhydramine (Benadryl) 25 mg PO
☐ Cetirizine (Zyrtec) 10 mg PO
☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Kisunla	☐ Step dosing: Infusion 1: 350 mg; Infusion 2 (4 weeks later): 700 mg; Infusion 3 (4 weeks later): 1,050 mg; Infusion 4 and every 4 weeks: 1,400 mg ☐ Maintenance: 1,400 mg	IV	☐ Every 4 weeks (after initial x3 step-dosing infusions) ☐ Every 4 weeks

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Krystexxa *pegloticase*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Chronic Gout, ICD 10: M1A.

☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ G6PD results

☐ Documentation of initiation of Methotrexate and folic acid

☐ Labs and tests supporting diagnosis

☐ Serum uric acid level within 1 month for initiation of therapy, within 48 hours for ongoing treatments

☐ Demographics

☐ Office/progress notes

PRE-MEDICATION

Recommendations per PI are pre-selected; these will be given unless otherwise specified.

☐ Acetaminophen (Tylenol) 500 mg PO

☐ Famotidine 20 mg IV

☑ Methylprednisolone (Solu-Medrol) 125 mg IVP

☑ Diphenhydramine (Benadryl) 25 mg PO

☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Krystexxa	8 mg	IV	Every 2 weeks

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Lamzede *velmanase alfa-tycv*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Non-central nervous system manifestations of alpha-mannosidosis in adult and pediatric patients, ICD 10: E77.1

☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☐ Methylprednisolone (Solu-Medrol) 125 mg IVP

☐ Diphenhydramine (Benadryl) 25 mg PO ☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Lamzede	1 mg/kg (actual body weight)	IV	Every week

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Leqembi *lecanemab-irmb*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Alzheimer's disease with early onset, ICD 10: G30.0
☐ Alzheimer's disease with late onset, ICD 10: G30.1
☐ Other Alzheimer's disease, ICD 10: G30.8
☐ Alzheimer's disease, unspecified, ICD 10: G30.9
☐ Mild cognitive impairment, ICD 10: G31.84

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Baseline MRI within 1 year
☐ Demographics
☐ Office/progress notes
☐ Repeat MRIs needed prior to the 3rd, 5th, 7th and 14th infusion (more frequently if ARIA suspected)
☐ Labs and tests supporting diagnosis

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO
☐ Famotidine 20 mg IV
☐ Methylprednisolone (Solu-Medrol) 125 mg IVP
☐ Diphenhydramine (Benadryl) 25 mg PO
☐ Cetirizine (Zyrtec) 10 mg PO
☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Loading Dose	10 mg/kg	IV	☐ Every 2 weeks for 12 months
Maintenance Dose	10 mg/kg	IV	Every 2 weeks for remaining 6 months and then: ☐ Every 2 weeks ☐ Every 4 weeks

ORDER DURATION: Maximum 12 months from the date of provider signature. A new signed order is required for continued treatment beyond 12 months, regardless of loading or maintenance phase.

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Leqvio *inclisiran*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

PRIMARY DIAGNOSIS

Provider must specify

☐ Disorders of lipoprotein metabolism, ICD 10: E78.

☐ Other: _____

SECONDARY DIAGNOSIS

Provider must specify

☐ Atherosclerotic heart disease, ICD 10: I25. _____

☐ Ischemic heart disease, ICD 10: _____

☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Demographics
☐ Office/progress notes
☐ Labs and tests supporting diagnosis
☐ Manufacturer Referral Checklist Form

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO
☐ Famotidine 20 mg IV
☐ Methylprednisolone (Solu-Medrol) 125 mg IVP
☐ Diphenhydramine (Benadryl) 25 mg PO
☐ Cetirizine (Zyrtec) 10 mg PO
☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Leqvio	284 mg	Subcutaneous inj.	☐ Month 0, 3, then repeat every 6 months ☐ Every 6 months

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Lumvoa *veligrotug-vvze*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Thyrotoxicosis, ICD 10: E05. _____

☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Hearing test completed prior to treatment
☐ Labs and tests supporting diagnosis
☐ Demographics
☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO
☐ Famotidine 20 mg IV
☐ Methylprednisolone (Solu-Medrol) 125 mg IVP
☐ Diphenhydramine (Benadryl) 25 mg PO
☐ Cetirizine (Zyrtec) 10 mg PO
☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Lumvoa	10 mg/kg every three weeks for a total of 5 infusions	IV	Every 3 weeks for 5 doses

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Nucala *mepolizumab*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Severe asthma (age 6+), ICD 10: ☐ J45.50 ☐ J45.51 ☐ J45.52

☐ Hypereosinophilic syndrome, ICD 10: D72.119

☐ Chronic rhinosinusitis with nasal polyps, ICD 10: J33.8

☐ Eosinophilic granulomatosis with polyangiitis, ICD 10: M30.1

☐ COPD, ICD 10: J44. _____

☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO

☐ Famotidine 20 mg IV

☐ Methylprednisolone (Solu-Medrol) 125 mg IVP

☐ Diphenhydramine (Benadryl) 25 mg PO

☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Nucala	☐ 40mg ☐ 100mg ☐ 300mg	Subcutaneous inj.	Every 4 weeks

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Nulojix *belatacept*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Kidney transplant status, ICD 10: Z94.0

☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Negative TB results
☐ Demographics
☐ Labs and tests supporting diagnosis
☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO
☐ Famotidine 20 mg IV
☐ Methylprednisolone (Solu-Medrol) 125 mg IVP
☐ Diphenhydramine (Benadryl) 25 mg PO
☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Nulojix	☐ Dosing for Initial Phase 10mg/kg on Day 1, Day 5, End of Weeks 2, 4, 6, and 12 ☐ Dosing for maintenance phase 5mg/kg every 4 weeks (+/- 3 days) thereafter	IV	Refer to Dose for Schedule

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Ocrevus *ocrelizumab*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Relapsing-remitting multiple sclerosis (RRMS), ICD 10: G35.A
☐ Active secondary progressive multiple sclerosis (SPMS), ICD 10: G35.C1
☐ Active primary progressive multiple sclerosis (PPMS), ICD 10: G35.B1
☐ Non-active primary progressive multiple sclerosis (PPMS), ICD 10: G35.B2
☐ Clinically isolated syndrome (CIS), ICD 10: G36.9
☐ Relapsing-remitting MS in pediatric patients 10 years and older who weigh 25 kg or more, ICD 10: G35.A

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ HBsAg (Hepatitis B surface antigen) & Anti-HBc (Hepatitis B core antibody, total or IgG)
☐ Labs and tests supporting diagnosis
☐ Baseline liver function tests (LFTs) (ALT, AST, bilirubin, alkaline phosphatase) within 6 months
☐ Demographics
☐ Office/progress notes

PRE-MEDICATION

Recommendations per PI are pre-selected; these will be given unless otherwise specified.

☑ Acetaminophen (Tylenol) 500 mg PO
☑ Famotidine 20 mg IV
☑ Methylprednisolone (Solu-Medrol) 125 mg IVP
☑ Diphenhydramine (Benadryl) 25 mg PO
☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Ocrevus	☐ Initial treatment: 300 mg at week 0 and 2, then 600 mg ☐ Maintenance treatment: 600 mg	IV	☐ Every 24 weeks ☐ Every 6 months

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Ocrevus Zunovo *ocrelizumab and hyaluronidase-ocsq*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Relapsing-remitting multiple sclerosis (RRMS), ICD 10: G35.A
☐ Active secondary progressive multiple sclerosis (SPMS), ICD 10: G35.C1
☐ Active primary progressive multiple sclerosis (PPMS), ICD 10: G35.B1
☐ Non-active Primary progressive multiple sclerosis (PPMS), ICD 10: G35.B2
☐ Clinically isolated syndrome (CIS), ICD 10: G36.9

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ HBsAg (Hepatitis B surface antigen) & Anti-HBc (Hepatitis B core antibody, total or IgG)
☐ Labs and tests supporting diagnosis
☐ Baseline liver function tests (LFTs) (ALT, AST, bilirubin, alkaline phosphatase) within 6 months
☐ Demographics
☐ Office/progress notes

PRE-MEDICATION

Recommendations per PI are pre-selected; these will be given unless otherwise specified.

☑ Dexamethasone 20 mg PO
☐ Diphenhydramine (Benadryl) 25 mg PO
☑ Loratadine 10 mg PO
☑ Acetaminophen (Tylenol) 500 mg PO
☐ Desloratadine 5 mg PO
☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

We will NOT administer IV premedications for this medication.

MEDICATION ORDER

MEDICATION	DOSE / FREQUENCY	ROUTE
Ocrevus Zunovo	920mg/23ml ocrelizumab and 23,000 units hyaluronidase every 6 months	SubQ in Abdomen

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Omvoh *mirikizumab-mrkz*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Moderate to severe active ulcerative colitis, ICD 10: K51.
☐ Moderate to severe active Crohn's disease, ICD 10: K50.
☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Negative TB test
☐ Office/progress notes
☐ Demographics
☐ Labs and tests supporting diagnosis

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO
☐ Famotidine 20 mg IV
☐ Methylprednisolone (Solu-Medrol) 125 mg IVP
☐ Diphenhydramine (Benadryl) 25 mg PO
☐ Cetirizine (Zyrtec) 10 mg PO
☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DIAGNOSIS	DOSE / FREQUENCY	ROUTE
Omvoh	☐ Ulcerative Colitis	Initial: 300 mg at weeks 0, 4, & 8; then maintenance: 200 mg at week 12 and every 4 weeks	☐ IV ☐ SubQ
	☐ Crohn's	Initial: 900 mg at weeks 0, 4, & 8; then maintenance: 300 mg at week 12 and every 4 weeks	☐ IV ☐ SubQ

x3 IV infusions need to be completed prior to SubQ injections.
☐ Check this box if you do NOT want Infuse Care to complete the insurance portion for SubQ.

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Onpattro *patisiran*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Neuropathic heredofamilial amyloidosis, ICD 10: E85.1

☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

Recommendations per PI are pre-selected; these will be given unless otherwise specified.

☑ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☑ Methylprednisolone (Solu-Medrol) 125 mg IVP

☑ Diphenhydramine (Benadryl) 25 mg PO ☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Onpattro	☐ 0.3 mg/kg (for pt weight less than 100kg) ☐ 30 mg (for pt weight 100 kg or more)	IV	Every 3 weeks

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Opdivo Qvantig *nivolumab and hyaluronidase-nvhy*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

Description: _____

ICD 10: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☐ Methylprednisolone (Solu-Medrol) 125 mg IVP

☐ Diphenhydramine (Benadryl) 25 mg PO ☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE / FREQUENCY	ROUTE
OPDIVO Qvantig	☐ 300 mg/5,000 units every 2 weeks ☐ 600 mg/10,000 units every 4 weeks ☐ 600 mg/10,000 units every 2 weeks ☐ 1,200 mg/20,000 units every 4 weeks ☐ 900 mg/15,000 units with platinum-doublet chemotherapy on the same day every 3 weeks for 3 cycles ☐ 900 mg/15,000 units with platinum-doublet chemotherapy on the same day every 3 weeks for up to 4 cycles ☐ 900 mg/15,000 units every 3 weeks with cisplatin and gemcitabine on the same day for up to 6 cycles	Subcutaneous injection

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Orencia *abatacept*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Adult Rheumatoid Arthritis, ICD 10: M05. or M06.
☐ Psoriatic Arthritis, ICD 10: L40.
☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Negative TB
☐ HBsAg (Hepatitis B surface antigen) & Anti-HBc (Hepatitis B core antibody, total or IgG)
☐ Demographics
☐ Labs and tests supporting diagnosis
☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO
☐ Famotidine 20 mg IV
☐ Methylprednisolone (Solu-Medrol) 125 mg IVP
☐ Diphenhydramine (Benadryl) 25 mg PO
☐ Cetirizine (Zyrtec) 10 mg PO
☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Orencia	☐ 500 mg (Pt weight less than 60 kg) ☐ 750 mg (Pt weight between 60 to 100 kg) ☐ 1,000 mg (Pt weight more than 100 kg)	IV	☐ Weeks 0, 2, 4, then every 4 weeks ☐ Every 4 weeks

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Papzimeos *zopapogene imadenovec-drba*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Adults with recurrent respiratory papillomatosis: benign neoplasm of larynx, ICD 10: D14.1

☐ Adults with recurrent respiratory papillomatosis, ICD 10: _____

☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☐ Diphenhydramine (Benadryl) 25 mg PO
☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE / FREQUENCY	ROUTE
Papzimeos	Dose 1: Day 1 Dose 2: Week 2 Dose 3: Week 6 Dose 4: Week 12	Subcutaneous inj.

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Pasatru *garetosmab-grts*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Fibrodysplasia ossificans progressiva (FOP), ICD 10: M61.1 _____

☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☐ Methylprednisolone (Solu-Medrol) 125 mg IVP

☐ Diphenhydramine (Benadryl) 25 mg PO ☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE / FREQUENCY	ROUTE
Pasatru	Starting dosage: 10 mg/kg every 4 weeks	IV

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Pemgarda *pemivibart*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Pre-exposure prophylaxis of coronavirus disease 2019 (COVID-19) in adults and adolescents (12 years of age) who have moderate-to-severe immune compromise, ICD 10: _____

☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☐ Methylprednisolone (Solu-Medrol) 125 mg IVP

☐ Diphenhydramine (Benadryl) 25 mg PO ☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Pemgarda	☐ Initial Dose: 4500 mg administered as a single intravenous infusion. ☐ Repeat Dose: 4500 mg administered as a single intravenous infusion approximately every 3 months.	IV	q 3 months

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Perjeta *pertuzumab*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ In combination with trastuzumab and docetaxel for adults with HER2-positive metastatic breast cancer (MBC) who have not received prior anti-HER2 therapy or chemotherapy for metastatic disease, ICD 10: C50._____ and C78._____ or C79._____

☐ In combination with trastuzumab and chemotherapy as:

- ☐ Neoadjuvant treatment of adults with HER2-positive, locally advanced, inflammatory, or early stage breast cancer (either greater than 2 cm in diameter or node positive) as part of a complete treatment regimen for early breast cancer
- ☐ Adjuvant treatment of adults with HER2-positive early breast cancer at high risk of recurrence, ICD 10: C50._____

☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Demographics
☐ Office/progress notes
☐ Labs and tests supporting diagnosis
☐ Documented combination therapy of trastuzumab & chemotherapy
☐ Confirmed HER2-Positive Status

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO
☐ Famotidine 20 mg IV
☐ Methylprednisolone (Solu-Medrol) 125 mg IVP
☐ Diphenhydramine (Benadryl) 25 mg PO
☐ Cetirizine (Zyrtec) 10 mg PO
☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE / FREQUENCY	ROUTE
Perjeta	initial PERJETA dose is 840 mg administered as a 60-minute intravenous infusion, followed every 3 weeks thereafter by 420 mg administered as a 30 to 60 minute intravenous infusion	IV

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Phesgo *pertuzumab, trastuzumab, and hyaluronidase-zzxf*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

In combination with chemotherapy as:

☐ Neoadjuvant treatment of patients with HER2-positive, locally advanced, inflammatory, or early stage breast cancer (either greater than 2 cm in diameter or node positive) as part of a complete treatment regimen for early breast cancer

☐ Adjuvant treatment of patients with HER2-positive early breast cancer at high risk of recurrence

In combination with:

☐ Docetaxel for treatment of patients with HER2-positive metastatic breast cancer (MBC) who have not received prior anti-HER2 therapy or chemotherapy for metastatic disease

Malignant neoplasm of the female breast, ICD 10: C50. _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Documentation of which combined therapy patient is currently on
☐ Labs and tests supporting diagnosis
☐ Demographics
☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO
☐ Famotidine 20 mg IV
☐ Methylprednisolone (Solu-Medrol) 125 mg IVP
☐ Diphenhydramine (Benadryl) 25 mg PO
☐ Cetirizine (Zyrtec) 10 mg PO
☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Phesgo	Initial dose: 1,200 mg pertuzumab / 600 mg trastuzumab / 30,000 units hyaluronidase Maintenance: 600 mg pertuzumab / 600 mg trastuzumab / 20,000 units hyaluronidase	Subcutaneous	Initial dose, then every 3 weeks

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Denosumab *Prolia & biosimilars*

☐ Conexxence (denosumab-bnht) ☐ Stoboclo (denosumab-bmwo) ☐ Jubbonti (denosumab-bbdz)
☐ Prolia (denosumab)
☐ Dispense as written (DAW) Will substitute for biosimilar or reference product based on insurance and availability unless DAW is checked.

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Osteoporosis, with pathological fx, ICD 10: M80.
☐ Osteoporosis, without pathological fx, ICD 10: M81.
☐ If M80., location of previous fracture: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Normal calcium within 6 months of referral
☐ Labs and tests supporting diagnosis
☐ Demographics
☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☐ Methylprednisolone (Solu-Medrol) 125 mg IVP
☐ Diphenhydramine (Benadryl) 25 mg PO ☐ Cetirizine (Zyrtec) 10 mg PO
☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Denosumab	60 mg	Subcutaneous inj.	Every 6 months

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Qutenza *capsaicin 8% topical system*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Type I diabetes mellitus with diabetic neuropathy, ICD 10: E10.4
☐ Type II diabetes mellitus with diabetic neuropathy, ICD 10: E11.4
☐ Postherpetic neuropathy, ICD 10: B02.
☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO
☐ Famotidine 20 mg IV
☐ Methylprednisolone (Solu-Medrol) 125 mg IVP
☐ Diphenhydramine (Benadryl) 25 mg PO
☐ Cetirizine (Zyrtec) 10 mg PO
☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Qutenza	☐ Single 30 minute application of up to 4 topical systems ☐ Single 60 minute application of up to 4 topical systems	# of patches: _____ Site(s): _____ (indicate location(s) on body)	☐ Every 3 months ☐ Other: _____

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Reclast *zoledronic acid*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Weight _____ kg Height _____

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last Reclast dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Age-related osteoporosis, without pathological fx, ICD 10: M81.0
☐ Osteoporosis, with pathological fx, ICD 10: M80._____
If M80., location of fracture: _____
☐ Other osteoporosis (e.g., steroid-induced), ICD 10: M81.8
☐ Paget's disease of bone, ICD 10: M88._____
☐ Other dx _____ ICD 10 _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Serum creatinine + calculated CrCl within 30 days
☐ Serum calcium within 30 days
☐ DEXA scan within 2 years and/or FRAX score
☐ Dental evaluation / oral health documented
☐ Demographics + copy of insurance cards
☐ Office/progress notes, incl. tried & failed therapies
☐ Current medication list
☐ Labs and tests supporting diagnosis

Taking daily calcium + vitamin D supplements: ☐ Yes ☐ No

Currently receiving Zometa or another bisphosphonate: ☐ No ☐ Yes — drug / last dose: _____

PRE-MEDICATION

Not typically indicated; acetaminophen may reduce acute-phase reactions

☐ Acetaminophen (Tylenol) 650 mg PO
☐ Diphenhydramine (Benadryl) 25 mg PO
☐ Famotidine 20 mg IV
☐ Loratadine (Claritin) 10 mg PO
☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Reclast (zoledronic acid)	5 mg / 100 mL	IV infusion over no less than 15 minutes	☐ Once yearly ☐ Once every 2 years ☐ Single dose (Paget's)

☐ Hydration: 0.9% sodium chloride _____ mL IV prior to infusion ☐ Generic zoledronic acid 5 mg/100 mL OK

LABS / SPECIAL INSTRUCTIONS

Infuse Care obtains serum creatinine and calculates CrCl (Cockcroft-Gault, actual body weight) before each dose. Reclast is contraindicated with CrCl < 35 mL/min, acute renal impairment, or uncorrected hypocalcemia. Patients receiving Zometa should not be treated with Reclast.

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Infliximab *Remicade & biosimilars*

- ☐ Infliximab (Remicade)
- ☐ Infliximab-axxq (Avsola)
- ☐ Infliximab-dyyb (Inflectra)
- ☐ Infliximab-abda (Renflexis)
- ☐ Dispense as written (DAW) Will substitute for biosimilar or reference product based on insurance and availability unless DAW is checked.

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

- ☐ Rheumatoid Arthritis, ICD 10: M05. or M06.
- ☐ Ankylosing Spondylitis, ICD 10: M45.
- ☐ Plaque Psoriasis, ICD 10: L40.0
- ☐ Crohn's Disease, ICD 10: K50.
- ☐ Psoriatic Arthritis, ICD 10: L40.
- ☐ Ulcerative Colitis, ICD 10: K51.
- ☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

- ☐ Negative TB
- ☐ Demographics
- ☐ Office/progress notes
- ☐ HBsAg (Hepatitis B surface antigen) & Anti-HBc (Hepatitis B core antibody, total or IgG)
- ☐ Labs and tests supporting diagnosis

PRE-MEDICATION

Recommendations per PI are pre-selected; these will be given unless otherwise specified.

- ☑ Acetaminophen (Tylenol) 500 mg PO
- ☐ Famotidine 20 mg IV
- ☑ Methylprednisolone (Solu-Medrol) 125 mg IVP
- ☑ Diphenhydramine (Benadryl) 25 mg PO
- ☐ Cetirizine (Zyrtec) 10 mg PO
- ☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Infliximab	☐ _____ mg/kg ☐ _____ mg	IV	☐ Weeks 0, 2, 6 and then every 8 weeks ☐ Every 8 weeks ☐ Every _____ weeks

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Rituximab *Rituxan & biosimilars*

- ☐ Rituximab (Rituxan)
- ☐ Rituximab-abbs (Truxima)
- ☐ Rituximab-pvvr (Ruxience)
- ☐ Rituximab-arrx (Riabni)
- ☐ Dispense as written (DAW) Will substitute for biosimilar or reference product based on insurance and availability unless DAW is checked.

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

- ☐ Rheumatoid Arthritis, ICD 10: M05._____ or M06._____
- ☐ Microscopic Polyangiitis, ICD 10: M31.7
- ☐ Granulomatosis with Polyangiitis, ICD 10: M31._____
- ☐ Pemphigus Vulgaris, ICD 10: L10.0
- ☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

- ☐ HBsAg (Hepatitis B surface antigen) & Anti-HBc (Hepatitis B core antibody, total or IgG)
- ☐ Demographics
- ☐ Labs and tests supporting diagnosis
- ☐ Office/progress notes

PRE-MEDICATION

Recommendations per PI are pre-selected; these will be given unless otherwise specified.

- ☑ Acetaminophen (Tylenol) 500 mg PO
- ☑ Famotidine 20 mg IV
- ☑ Methylprednisolone (Solu-Medrol) 125 mg IVP
- ☑ Diphenhydramine (Benadryl) 25 mg PO
- ☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Rituximab	☐ 500 mg ☐ 1,000 mg ☐ 375 mg/m2	IV	☐ Day 0 and 14 x1 course ☐ Day 0 and 14, then repeat Day 0 and 14 every 6 months ☐ Day 0, 7, 14, and 21 x1 course ☐ Other: _____

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Rystiggo *rozanolixizumab-noli*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Myasthenia Gravis (w/out acute exacerbation): G70.00

☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☐ Methylprednisolone (Solu-Medrol) 125 mg IVP

☐ Diphenhydramine (Benadryl) 25 mg PO ☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Rystiggo	☐ <50kg = 420mg/3ml ☐ 51-99kg = 560mg/4ml ☐ >100kg = 840mg/6ml	Subcutaneous inj.	1x week for 6 weeks; _____ cycles (subsequent cycles start no sooner than 63 days (~9 weeks) from the start of the previous cycle)

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Saphnelo *anifrolumab-fnia*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Systemic Lupus Erythematosus, ICD 10: M32.

☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☐ Methylprednisolone (Solu-Medrol) 125 mg IVP

☐ Diphenhydramine (Benadryl) 25 mg PO ☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Saphnelo	300 mg	IV	Every 4 weeks

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Simponi Aria *golimumab*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Rheumatoid Arthritis, ICD 10: M05. or M06.
☐ Psoriatic Arthritis, ICD 10: L40.
☐ Ankylosing Spondylitis, ICD 10: M45.
☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Negative TB
☐ Demographics
☐ Office/progress notes
☐ HBsAg (Hepatitis B surface antigen) & Anti-HBc (Hepatitis B core antibody, total or IgG)
☐ Labs and tests supporting diagnosis

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO
☐ Famotidine 20 mg IV
☐ Methylprednisolone (Solu-Medrol) 125 mg IVP
☐ Diphenhydramine (Benadryl) 25 mg PO
☐ Cetirizine (Zyrtec) 10 mg PO
☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Simponi Aria	2 mg/kg	IV	☐ Weeks 0, 4 and then every 8 weeks ☐ Every 8 weeks

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Skyrizi *risankizumab-rzaa*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Crohn's Disease, ICD 10: K50.
☐ Ulcerative Colitis, ICD 10: K51.
☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Negative TB screening
☐ Office/progress notes
☐ Demographics
☐ Labs and tests supporting diagnosis

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO
☐ Famotidine 20 mg IV
☐ Methylprednisolone (Solu-Medrol) 125 mg IVP
☐ Diphenhydramine (Benadryl) 25 mg PO
☐ Cetirizine (Zyrtec) 10 mg PO
☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Skyrizi	Crohn's: 600 mg Ulcerative colitis: 1,200 mg	IV	Weeks 0, 4, 8
	Then maintenance dosing: ☐ 180 mg or ☐ 360 mg	Subcutaneous inj.	Week 12, then every 8 weeks

x3 IV infusions need to be completed prior to SubQ injections.
☐ Check this box if you do NOT want Infuse Care to complete the insurance portion for SubQ.

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Eculizumab *Soliris & biosimilars*

☐ Soliris (eculizumab) ☐ Bkemv (eculizumab-aeeb)
☐ Dispense as written (DAW) Will substitute for biosimilar or reference product based on insurance and availability unless DAW is checked.

PATIENT INFORMATION

Patient name _____ DOB _____
Mobile number _____ Patient weight _____ kg
Allergies _____
☐ Patient has known difficult venous access. Comments: _____
☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Myasthenia Gravis (without acute exacerbation), ICD 10: G70.00
☐ Myasthenia Gravis with acute exacerbation, ICD 10: G70.01
☐ Neuromyelitis Optica Spectrum Disorder, ICD 10: G36.0
☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____
Signature _____ Date _____
Contact name _____ Phone _____ Fax _____
Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Documentation of meningitis vaccine (at least 2 weeks before 1st infusion)
☐ Labs and tests supporting diagnosis
☐ Demographics
☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO
☐ Famotidine 20 mg IV
☐ Methylprednisolone (Solu-Medrol) 125 mg IVP
☐ Diphenhydramine (Benadryl) 25 mg PO
☐ Cetirizine (Zyrtec) 10 mg PO
☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE / FREQUENCY	ROUTE
Soliris	☐ Initial: 900 mg weekly x 4 weeks, 1,200 mg week 5, then 1,200 mg every 2 weeks thereafter ☐ Maintenance: 1,200 mg every 2 weeks ☐ Other: _____	IV

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Solu-Medrol *methylprednisolone*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Primary diagnosis: _____

☐ Secondary diagnosis: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ N/A ☐ Demographics ☐ Labs and tests supporting diagnosis
☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☐ Methylprednisolone (Solu-Medrol) 125 mg IVP

☐ Diphenhydramine (Benadryl) 25 mg PO ☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Solu-Medrol	_____mg	IV	☐ Once ☐ Other: _____

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Spevigo *spesolimab-sbzo*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Generalized Pustular Psoriasis: L40.1

☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Negative TB ☐ Demographics ☐ Labs and tests supporting diagnosis

☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☐ Methylprednisolone (Solu-Medrol) 125 mg IVP

☐ Diphenhydramine (Benadryl) 25 mg PO ☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Spevigo	900 mg. x 1, May repeat 900 mg. dose in one week with persistent flare.	IV	☐ x 1 initial dose ☐ x 1 repeat dose

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Ustekinumab *Stelara & biosimilars*

- ☐ Selardsi (ustekinumab-aekn)
- ☐ Steqeyma (ustekinumab-stba)
- ☐ Yesintek (ustekinumab-kfce)
- ☐ Stelara (ustekinumab)
- ☐ Otulfi (ustekinumab-aauz)
- ☐ Wezlana (ustekinumab-auub)
- ☐ Dispense as written (DAW) Will substitute for biosimilar or reference product based on insurance and availability unless DAW is checked.

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

- ☐ Psoriatic Arthritis, ICD 10: L40.
- ☐ Crohn's Disease, ICD 10: K50.
- ☐ Psoriasis, ICD 10: L40.
- ☐ Ulcerative Colitis, ICD 10: K51.
- ☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

- ☐ Negative TB
- ☐ Office/progress notes
- ☐ Demographics
- ☐ Labs and tests supporting diagnosis

PRE-MEDICATION

Not typically indicated

- ☐ Acetaminophen (Tylenol) 500 mg PO
- ☐ Famotidine 20 mg IV
- ☐ Methylprednisolone (Solu-Medrol) 125 mg IVP
- ☐ Diphenhydramine (Benadryl) 25 mg PO
- ☐ Cetirizine (Zyrtec) 10 mg PO
- ☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Ustekinumab	☐ 260 mg ☐ 390 mg ☐ 520 mg	IV	x 1 dose
	☐ 45 mg ☐ 90 mg	Subcutaneous inj.	☐ 8 weeks after initial IV dose then every 8 weeks ☐ Every 8 weeks

x1 IV infusion needs to be completed prior to SubQ injections.
☐ Check this box if you do NOT want Infuse Care to complete the insurance portion for SubQ.

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Tepezza *teprotumumab-trbw*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Thyrotoxicosis, ICD 10: E05.

☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Thyroid panel within 6 months of referral prior to initiation of therapy

☐ Demographics

☐ Office/progress notes

☐ Hearing test completed prior to treatment

☐ Labs and tests supporting diagnosis

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO

☐ Famotidine 20 mg IV

☐ Methylprednisolone (Solu-Medrol) 125 mg IVP

☐ Diphenhydramine (Benadryl) 25 mg PO

☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE / FREQUENCY	ROUTE
Tepezza	10 mg/kg x1, followed by 20 mg/kg every 3 weeks x7 doses	IV

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Tezspire *tezepelumab-ekko*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Add-on maintenance treatment of adult and pediatric patients aged 12 years and older with severe asthma, ICD 10: J45.

☐ Add-on maintenance treatment of adult and pediatric patients aged 12 years and older with inadequately controlled chronic rhinosinusitis with nasal polyps (CRSwNP), ICD 10: J32.9 (Chronic sinusitis, unspecified) and J33.9 (Nasal polyp, unspecified)

☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☐ Methylprednisolone (Solu-Medrol) 125 mg IVP

☐ Diphenhydramine (Benadryl) 25 mg PO ☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Tezspire	210 mg	Subcutaneous inj.	Every 4 weeks

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Tremfya *guselkumab*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Ulcerative Colitis, ICD 10: K51.
☐ Moderately to severely active Crohn's disease, ICD 10: K50.
☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Negative TB test
☐ Office/progress notes
☐ Demographics
☐ Labs and tests supporting diagnosis

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO
☐ Famotidine 20 mg IV
☐ Methylprednisolone (Solu-Medrol) 125 mg IVP
☐ Diphenhydramine (Benadryl) 25 mg PO
☐ Cetirizine (Zyrtec) 10 mg PO
☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

	DOSE	ROUTE	FREQUENCY
Tremfya – IV induction	☐ 200 mg	IV	Weeks 0, 4, 8
Tremfya – SubQ maintenance	☐ 100 mg or ☐ 200 mg	Subcutaneous inj.	☐ Week 16, then every 8 weeks ☐ Week 12, then every 4 weeks

x3 IV infusions need to be completed prior to self-administered SubQ injections.
☐ Check this box if you do NOT want Infuse Care to complete the insurance portion for SubQ.

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Tyruko *natalizumab-sztn*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Relapsing-remitting multiple sclerosis (RRMS), ICD 10: G35.A
☐ Active secondary progressive multiple sclerosis (SPMS), ICD 10: G35.C1
☐ Clinically isolated syndrome, ICD 10: G36.9
☐ Moderately to severely active Crohn's disease, ICD 10: K50.0
☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Demographics
☐ Tyruko REMS enrollment
☐ Labs and tests supporting diagnosis
☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO
☐ Famotidine 20 mg IV
☐ Methylprednisolone (Solu-Medrol) 125 mg IVP
☐ Diphenhydramine (Benadryl) 25 mg PO
☐ Cetirizine (Zyrtec) 10 mg PO
☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Tyruko	300 mg	IV	☐ Every 28 days ☐ Other: _____

LABS / SPECIAL INSTRUCTIONS

☐ Check if JCV (JC virus antibody) labs should be drawn and monitored by the infusion center. Timeframe: _____

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Tysabri *natalizumab*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Relapsing-remitting multiple sclerosis (RRMS), ICD 10: G35.A
☐ Active secondary progressive multiple sclerosis (SPMS), ICD 10: G35.C1
☐ Clinically isolated syndrome, ICD 10: G36.9
☐ Moderately to severely active Crohn's disease, ICD 10: K50.0
☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Demographics
☐ TOUCH portal enrollment
☐ Labs and tests supporting diagnosis
☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO
☐ Famotidine 20 mg IV
☐ Methylprednisolone (Solu-Medrol) 125 mg IVP
☐ Diphenhydramine (Benadryl) 25 mg PO
☐ Cetirizine (Zyrtec) 10 mg PO
☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Tysabri	300 mg	IV	☐ Every 28 days ☐ Other: _____

LABS / SPECIAL INSTRUCTIONS

☐ Check if JCV (JC virus antibody) labs should be drawn and monitored by the infusion center. Timeframe: _____

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Ultomiris *ravulizumab-cwvz*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Myasthenia Gravis (without acute exacerbation), ICD 10: G70.00
☐ Myasthenia Gravis with acute exacerbation, ICD 10: G70.01
☐ Paroxysmal Nocturnal Hemoglobinuria (PNH), ICD 10: D59.5
☐ Atypical Hemolytic Uremic Syndrome (aHUS), ICD 10: D59. _____
☐ Neuromyelitis optica spectrum disorder (NMOSD) who are anti-aquaporin-4 (AQP4) antibody positive, ICD 10: G36.0
☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Proof of meningococcal vaccination at least 2 weeks prior to start of treatment (If urgent Ultomiris therapy is indicated in an unvaccinated patient, administer meningococcal vaccine(s) as soon as possible and provide patients with two weeks of antibacterial drug prophylaxis
☐ Demographics
☐ Labs and tests supporting diagnosis
☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO
☐ Famotidine 20 mg IV
☐ Methylprednisolone (Solu-Medrol) 125 mg IVP
☐ Diphenhydramine (Benadryl) 25 mg PO
☐ Cetirizine (Zyrtec) 10 mg PO
☐ Other _____ Dose _____ Route _____

Order valid for 1 year from date of signature unless otherwise specified here: _____

Ultomiris *(continued)*

MEDICATION ORDER

MEDICATION	INDICATIONS	BODY WEIGHT (KG)	LOADING DOSE (MG)**	MAINTENANCE DOSE (MG)	INTERVAL	ROUTE
Ultomiris	☐ PNH or aHUS	5 to <10	600	300	Every 4 weeks	IV
		10 to <20	600	600		
		20 to <30	900	2,100	Every 8 weeks	
		30 to <40	1,200	2,700		
	☐ PNH, aHUS, gMG, or NMOSD	40 to <60	2,400	3,000	Every 8 weeks	
		60 to <100	2,700	3,300		
		100 or greater	3,000	3,600		
	☐ Other: _____					

**Not currently on Ultomiris or eculizumab: weight-based loading dose begins at treatment start; first weight-based maintenance dose 2 weeks after the loading dose.
Currently treated with eculizumab: loading dose begins at the time of the next scheduled eculizumab dose; first weight-based maintenance dose 2 weeks after the loading dose.

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Uplizna *inebilizumab-cdon*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Neuromyelitis optica spectrum disorder (NMOSD) in adult patients who are anti-aquaporin-4 (AQP4) antibody positive, ICD 10: G36.0

☐ Immunoglobulin G4-related disease (IgG4-RD) in adult patients, ICD 10: D89.84

☐ Generalized myasthenia gravis (gMG) in adult patients who are antiacetylcholine receptor (AChR) or anti-muscle specific tyrosine kinase (MuSK) antibody positive, ICD 10: G70. _____

☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ HBsAg (Hepatitis B surface antigen) & Anti-HBc (Hepatitis B core antibody, total or IgG)

☐ Negative TB

☐ Demographics

☐ Labs and tests supporting diagnosis

☐ Office/progress notes

PRE-MEDICATION

Recommendations per PI are pre-selected; these will be given unless otherwise specified.

☑ Acetaminophen (Tylenol) 500 mg PO

☐ Famotidine 20 mg IV

☑ Methylprednisolone (Solu-Medrol) 125 mg IVP

☑ Diphenhydramine (Benadryl) 25 mg PO

☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Uplizna	300 mg	IV	☐ Initial: weeks 0 and 2, then every 6 months (starting 6 months from first infusion) ☐ Subsequent: every 6 months

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Uplizna *inebilizumab-cdon*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Neuromyelitis optica spectrum disorder (NMOSD) in adult patients who are anti-aquaporin-4 (AQP4) antibody positive, ICD 10: G36.0

☐ Immunoglobulin G4-related disease (IgG4-RD) in adult patients, ICD 10: D89.84

☐ Generalized myasthenia gravis (gMG) in adult patients who are antiacetylcholine receptor (AChR) or anti-muscle specific tyrosine kinase (MuSK) antibody positive, ICD 10: G70. _____

☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ HBsAg (Hepatitis B surface antigen) & Anti-HBc (Hepatitis B core antibody, total or IgG)

☐ Negative TB

☐ Demographics

☐ Labs and tests supporting diagnosis

☐ Office/progress notes

PRE-MEDICATION

Recommendations per PI are pre-selected; these will be given unless otherwise specified.

☑ Acetaminophen (Tylenol) 500 mg PO

☐ Famotidine 20 mg IV

☑ Methylprednisolone (Solu-Medrol) 125 mg IVP

☑ Diphenhydramine (Benadryl) 25 mg PO

☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Uplizna	300 mg	IV	☐ Initial: weeks 0 and 2, then every 6 months (starting 6 months from first infusion) ☐ Subsequent: every 6 months

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Vyepti *eptinezumab-jjmr*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Migraine, ICD 10: G43.

☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☐ Methylprednisolone (Solu-Medrol) 125 mg IVP

☐ Diphenhydramine (Benadryl) 25 mg PO ☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Vyepti	☐ 100 mg ☐ 300 mg	IV	Every 3 months

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Vyvgart Hytrulo *efgartigimod alfa and hyaluronidase-qvfc*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Myasthenia Gravis (without acute exacerbation), ICD 10: G70.00
☐ Myasthenia Gravis with acute exacerbation, ICD 10: G70.01
☐ Chronic inflammatory demyelinating polyneuropathy (CIDP), ICD 10: G61.81

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☐ Methylprednisolone (Solu-Medrol) 125 mg IVP

☐ Diphenhydramine (Benadryl) 25 mg PO ☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	FREQUENCY	ROUTE
Vyvgart Hytrulo	1,008 mg efgartigimod alfa / 11,200 units hyaluronidase per 5.6 mL	☐ gMG: once weekly for 4 weeks. Subsequent treatment cycles may be ordered based on clinical evaluation. Cycle interval: _____ ☐ CIDP: once weekly for 1 year	Subcutaneous inj.

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Vyvgart *efgartigimod alfa-fcab*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Myasthenia Gravis (without acute exacerbation), ICD 10: G70.00
☐ Myasthenia Gravis with acute exacerbation, ICD 10: G70.01
☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☐ Methylprednisolone (Solu-Medrol) 125 mg IVP

☐ Diphenhydramine (Benadryl) 25 mg PO ☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE / FREQUENCY	ROUTE
Vyvgart	10 mg/kg once weekly for 4 consecutive weeks Max dose 1,200 mg per infusion	IV

May be repeated based on clinical evaluation and patient response; the interval between treatment cycles may be individualized by the prescriber, including initiation of a subsequent cycle as early as 7 days after the last infusion of the prior cycle. Prescriber may adjust treatment-cycle frequency based on clinical response.
Treatment cycle/interval: _____

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Xolair *omalizumab*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Asthma, ICD 10: J45.
☐ Nasal Polyps, ICD 10: J33.
☐ Urticaria, ICD 10: L50.
☐ IgE-mediated Food Allergy, ICD 10: Z91.
☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO
☐ Famotidine 20 mg IV
☐ Methylprednisolone (Solu-Medrol) 125 mg IVP
☐ Diphenhydramine (Benadryl) 25 mg PO
☐ Cetirizine (Zyrtec) 10 mg PO
☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Xolair	☐ 75 mg ☐ 150 mg ☐ 225 mg ☐ 300 mg ☐ 375 mg	Subcutaneous inj.	☐ Every 2 weeks ☐ Every 4 weeks

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Yeztugo *lenacapavir*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Pre-exposure prophylaxis (PrEP) to reduce the risk of sexually acquired HIV-1 in adults and adolescents weighing at least 35 kg who are at risk for HIV-1 acquisition, ICD 10: Z29.81

☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Individuals must have a negative HIV-1 test prior to initiating

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO

☐ Famotidine 20 mg IV

☐ Methylprednisolone (Solu-Medrol) 125 mg IVP

☐ Diphenhydramine (Benadryl) 25 mg PO

☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Yeztugo	Day 1: 927 mg by subcutaneous injection (2 x 1.5 mL injections) & 600 mg orally (2 x 300 mg tablets) Day 2: 600 mg orally (2 x 300 mg tablets) at home Maintenance: 927 mg by subcutaneous injection (2 x 1.5 mL injections) every 6 months (26 weeks) from the date of the last injection, +/- 2 weeks	Day 1: clinic administers SQ injections and dispenses oral tablets Day 2: patient self-administers oral tablets at home (provided by clinic)	Every 6 months after 2 loading days

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Zoladex *goserelin implant 3.6 mg / 10.8 mg*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Locally confined prostate cancer (with flutamide), ICD 10: C61
☐ Advanced prostate cancer, ICD 10: C61
☐ Endometriosis, ICD 10: N80.9
☐ Dysfunctional uterine bleeding – endometrial thinning prior to endometrial ablation, ICD 10: N93. _____
☐ Advanced breast cancer (pre-/perimenopausal), ICD 10: C50.9 _____
☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☐ Methylprednisolone (Solu-Medrol) 125 mg IVP

☐ Diphenhydramine (Benadryl) 25 mg PO ☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE / FREQUENCY	ROUTE
Zoladex	☐ 3.6 mg every 28 days ☐ 3.6 mg, followed 28 days later by 10.8 mg (men only) ☐ 10.8 mg every 12 weeks (men only) ☐ Continue indefinitely ☐ Number of doses: _____ For endometriosis: maximum recommended treatment duration is 6 months	Subcutaneous inj.

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____