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# *Cancer Care Partnership*

# *Generic Infusion Orders*

# Please fax this form along with a copy of insurance cards, proof of authorization and clinical documentation to: (814) 231-7295 or call (814) 231-7800

## PATIENT INFORMATION REFERRING PHYSICIAN INFORMATION

Name Address

Physician Name Physician Address

City

State

Zip Code

Physician Phone ( )

Home Phone # Work Phone # DOB SSN

Physician Fax ( ) NPI# DEA# \_

State License#

Height Weight lbs

Drug Allergies

* NKDA Sex: □ Male or □ Female

**DIAGNOSIS: (ICD-10 required)**

* +
	+

**\*Ordering Provider’s office must obtain authorization for our facility to infuse:**

**We are OFFICE based facility: NPI: 1477891711 Tax ID: 800866636**

# PRIMARY INSURANCE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Authorization # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ End Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# SECONDARY INSURANCE:

# Authorization #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ End Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Will drug be Buy and Bill? \_\_\_\_\_\_\_\_\_\_ Patients Own Drug? \_\_\_\_\_\_**

## ORDERS:

* **Name of drug: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Frequency**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Route**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Premedication**:

*Any* ***prescription*** *oral meds must be ordered by provider through pts retail pharmacy for pt to self-administer.*

* Acetaminophen (Tylenol) \_\_\_\_ mg po 30 minutes prior to infusion. *May be taken at home*
* Loratadine (Claritin) 10 mg PO prior to infusion ( Will substitute po antihistamines with what is on CCP formulary)
* Diphenhydramine (Benadryl) \_\_\_ mg po prior to the infusion. *May be taken at home*.

OR

* Diphenhydramine (Benadryl) \_\_\_ mg IVP prior to infusion
* Solumedrol \_\_\_ mg IVP prior to infusion.
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hypersensitivity Reaction Management:**

***CCP Standing Orders for infusion reaction will be followed unless otherwise specified***

Includes the following:

Acetaminophen (Tylenol) 650 mg po x 1

Solumedrol 125 mg IVP x 1

Diphenhydramine (Benadryl) 50 mg IVP x 1

Pepcid 20 mg IVPB x 1

Hydrocortisone 100 mg IVP x 1

***Severe reactions will require us to transfer to ER and ordering provider will be notified***

Please provide best contact number for notification \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_for anaphylaxis or questions (please provide a backdoor #, cell, or pager)

**Signature, prescribing MD Date**

**Order Set Checklist:**

* **Infusion Order Set (Via this form)**
* **Insurance and Authorization Information**

***All Below to be provided with order set***

* **Lab Order Forms (Must be sent separately with patient )**
* **Most recent office consult note**
* **Pre-Treatment Screening Lab Results (Must have copy of each lab result)**
* **Signed Consent Form –if applicable**