Revere Health Infusion Services
2019 E. Riverside Drive, Suite A200 • St. George, UT 84790
Phone: 435.628.9298 • Fax: 435.628.9655

Infusion Center Orders

All treatments require appointments to ensure staff and drug availability
Limited same day services must be approved by speaking to a staff RN

REQUIRED INFO

TAX ID #: 87-0281028 NPI #: 1700946423

Patient First Name: _____ Last Name: _____

Patient DOB: _____ Patient Height: _____ Patient Weight: _____

❑ Male ICD(s): _____

❑ Female Diagnosis(es): _____

Primary Insurance: _____ ID#: _____

Secondary Insurance: _____ ID#: _____

Authorization #: _____ Date Range: _____

If no auth. required get name/call ref#: _____/_____ Date: _____

***Must attach pertinent information: Demographics, Clinic Notes, Labs, Imaging, Authorizations**

Standing order for 12 months:

❑ Yes ❑ No

I authorize reaction protocol to be administered by attending physician and staff:

❑ Yes ❑ No

PRE TREATMENT LABS:

❑ CBC ❑ Iron ❑ Hepatitis B
❑ CMP ❑ TB Skin Test ❑ Quantiferron
❑ Ferritin ❑ Other: _____

PRE TREATMENT MEDICATIONS:

❑ **PO** Acetaminophen 650mg 20 min. prior to treatment
❑ **PO** Diphenhydramine 20 min. prior to treatment
❑ 25mg ❑ 50mg
❑ **IV** Diphenhydramine-infuse over 20 minutes
❑ 25mg ❑ 50mg
❑ Other: _____

IV FLUIDS:

❑ Normal Saline ❑ 500ml
❑ 5% Dextrose ❑ 1000ml
❑ D5NS ❑ 2000ml
❑ Lactated Ringers Infuse **IV** over _____ hour(s)

MISCELLANEOUS: _____

Dose/Rate/Frequency: _____

INFLIXIMAB: *BIOLOGIC LABS REQUIRED

❑ **IV** Remicade-infuse over not less than 2 hours
❑ **IV** Renflexis-infuse over not less than 2 hours
❑ **IV** Inflectra-infuse over not less than 2 hours
❑ 5mg/kg at 0,2,6 weeks and then every 8 weeks
❑ 10 mg/kg every 8 weeks

STELARA: *BIOLOGIC LABS REQUIRED

❑ **IV** Stelara-infuse over at least 1 hour
❑ 260mg (55kg or less) x1 only
❑ 390mg (>55kg to 85 kg) x1 only
❑ 520mg (85kg or more) x1 only

***BIOLOGIC LABS Required within 6 months of new start and then yearly**

Hepatitis B Result: _____ Date: _____
Quantiferron Result: _____ Date: _____
TB Skin Test Result: _____ Date: _____
CXR (if indicated-fax results) Date: _____

ENTYVIO:

❑ **IV** Entyvio-infuse over 30 minutes
❑ 300mg at 0,2,6 weeks and then every 8 weeks

IRON THERAPY:

ALL IRON THERAPY REQUIRES FAILURE ON OR INTOLERANCE TO ORAL IRON. PLEASE PROVIDE TWO DIAGNOSES AND SUPPORTING DOCUMENTATION.

❑ **IV** Venofer 200mg over 20 mins. weekly x _____ doses
❑ **IV** Injectafer 750 mg over 20 mins. weekly x 2

PHYSICIAN SIGNATURE: _____ DATE: _____