Revere Health
Cancer Center

96 East Kimballs Lane • Draper, UT 84020
Phone: 801.655.5670 • Fax: 385.203.1344
1055 North 500 West • Provo, UT 84604
Phone: 801.374.2367 • Fax: 801.429.8015
1152 East 200 North • American Fork, UT 84003
Phone: 801.772.0698 • Fax: 801.772.0705
Toll free: 866.374.2367 • reverehealth.com

# Infusion Center Orders

*All treatments require appointments to ensure staff and drug availability.*

Patient Name:_____ DOB:_____ MRN:_____ Phone:_____

Diagnosis:_____ ICD 10 (s)_____

Prior Authorization Number:_____ **Date Range:**_____

*** Standing order for 12 months:** ☐ Yes ☐ No *** I authorize reaction protocol to be administered by administering staff:** ☐ Yes ☐ No

## PREMEDS

☐ Acetaminophen 325-650 mg
☐ Diphenhydramine 25-50 mg
☐ Other _____
☐ PO
☐ IV

## PRE-TREATMENT/ADDITIONAL LABS

☐ CBC ☐ Ferritin ☐ Other _____
☐ CMP ☐ Vanco Trough ☐ Other _____
☐ Uric Acid

## FLUIDS

Quantity: _____

☐ NS ☐ LR

## PHLEBOTOMY

Hemochromatosis
Target HCT: _____
Target Ferritin: _____

Polycythemia vera
Target HCT: _____
Frequency: _____
Last Labs: _____

## IRON THERAPY

**ALL** iron therapy will require patient to fail or be intolerant to oral iron and therefore will require two diagnosis.
* Must have documentation to support *

☐ Infed-300 mg weekly x 6 doses
☐ Infed _____
* 1st does requires 2 hours for "test dose"
☐ Venofer-200 mg weekly x ___ doses
☐ injectafer-750 mg x 2 doses
☐ Faraheme-510 mg x 2 doses

## BONE HEALTH

T Score: _____ (must be < -2.5)
☐ Prolia-60mg SQ Q6 months
☐ Reclast-5 mg yearly
☐ Zometa
*** Must have creatinine within past 28 days ***
☐ Q3 Months ☐ Q6 Months
☐ Monthly for _____ months
☐ Xgeva-120 mg
☐ Q28 Day
☐ Q3 Months
☐ Q6 Months

## GASTROENTEROLOGY

TB/Chest XR Date: _____ TB/Chest XR Results: _____

Dosage:
☐ Entyvio-300mg
☐ Remicade
☐ 5 mg/kg
☐ 10 mg/kg
☐ Stelara IV
☐ 260 mg
☐ 390 mg
☐ 520 mg
Frequency:
☐ 0, 2 & 6 weeks
☐ Q6 weeks
☐ Q8 weeks

## IVIG

☐ Gamunex
☐ Octagam
☐ Gammagard
Dose/Rate/Frequency: _____
_____

## MISCELLANEOUS

* Standard pre-medications will be administered according to PI unless otherwise specified *

☐ Ocrevus
☐ Tysabri
☐ Radicava
☐ Cinqair
☐ Nucala
☐ Krystexxa
☐ Rituxan
☐ Other _____
Dose/Rate/Frequency: _____
_____

Ordering Provider Name: _____ Date: _____

Original Physician Signature: _____ Office Phone Number: _____

To be same-day, you must call and speak with a staff member in Medical Oncology to ensure drug and space availability. All treatments require a written order. Please fax the order to **(801) 429-8015** in Provo or to **(801) 772-0705** in American Fork.