



Phone: (865) 862 - 4557

www.heartlandinfusion.com

Fax: (865) 862 – 4556
Alt. Fax: (865) 867 - 7081

Radicava Order Form

Please fax completed form with patient demographic information, front and back of insurance card (s), recent lab results, and recent office visit notes supporting diagnosis to (865) 862-4556.

Referral Status:	<input type="checkbox"/> New referral	<input type="checkbox"/> Dose or frequency change	<input type="checkbox"/> Order Renewal
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PATIENT INFORMATION

Name:					
Home Phone:	Cell Phone:				
Email:	Last four Social Security number				
DOB:	Height:	Weight:			
Allergies:					
ICD-10 Diagnosis Code:		Years with Disease:			
TB Test (Circle One):	Skin	Quantiferon	Chest Xray	Result:	Date:

LABORATORY ORDERS			
<input type="checkbox"/> CBC w/ Diff	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other	_____
<input type="checkbox"/> CRP	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other	_____
<input type="checkbox"/> CMP	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other	_____
<input type="checkbox"/> ESR	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Hepatic Panel	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Renal Panel	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Quantiferon TB (annually)		Due:	_____
<input type="checkbox"/> Other: _____			

Therapy Orders	
<input type="checkbox"/> Induction: Administer 60 mg Radicava (edaravone) IV daily for 14 consecutive days, followed by 14 consecutive drug-free days	
<input type="checkbox"/> Maintenance: Administer 60 mg Radicava (edaravone) IV 10 out of 14 days, followed by 14 consecutive drug-free days. Repeat every 28 days.	
<input type="checkbox"/> Nursing per Heartland Nursing Procedures (incl reaction management)	
Pre-Medications	
<input type="checkbox"/> Tylenol (acetaminophen) _____ mg PO	<input type="checkbox"/> No routine pre-medications required
<input type="checkbox"/> Solu-Medrol (methylprednisolone) _____ mg IV	<input type="checkbox"/> Zyrtec (cetirizine) 10 mg PO
<input type="checkbox"/> Benadryl (diphenhydramine) _____ mg <input type="checkbox"/> PO	<input type="checkbox"/> Claritin (loratadine) 10 mg PO
<input type="checkbox"/> Other: _____	<input type="checkbox"/> IV

PHYSICIAN INFORMATION

Physician's Name:		
License #:	NPI#:	DEA#:
Address:		
City:	State:	Zip:
Office Contact:	Email:	
Office Phone:	Office Fax:	

Physician Signature: _____ Date: _____

Patient is being referred to: Knoxville Morristown Kingsport