HEARTLAND INFUSION

Fax to Heartland (1.865.862.4556)
Questions? Call (1.865.862.4557)

Order Form

Please fax completed form with patient demographics, front and back of insurance card(s), recent lab results, and recent office visit notes supporting diagnosis to 865.862.4556.

Type of Referral: ☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Location: ☐ Jackson ☐ Knoxville ☐ Morristown ☐ Kingsport

PATIENT INFORMATION

First Name: ____________ Last Name: ____________ DOB: ____________ Gender: (**check one**) ☐ M ☐ F

Home Phone: ____________ Mobile Phone: ____________

Email: ____________ Last 4 of SS#: ____________

Allergies: ____________ Height: ________ Weight: ________

ICD-10 Diagnosis Code(s): ____________ Date of Diagnosis: ____________

TB Test (**circle one**): Skin Quantiferon Chest X-ray Result: ____________ Date: ________

THERAPY ORDERS

☐ **Heartland to select product (based on clinical necessity, patient insurance, and product availability)** ☐ **Dispense as written**

☐ ____________ ☐ ____________

☐ Induction: Administer _______ mg/kg **OR** ______ mg (flat dose) at weeks ____________ then every ______ weeks

☐ Maintenance: Administer _______ mg/kg **OR** _______ mg (flat dose) every ______ weeks

Other (specify): ____________

☐ DAW - Do not round up to nearest vial size (Heartland policy to round up if ≥ 10mg of next vial size)

☐ Nursing per Heartland Nursing Procedures (include reaction management)

PRE-MEDICATION

☐ **No routine pre-medications required**

☐ Tylenol (acetaminophen) ________mg PO

☐ Solu-Medrol (methylprednisolone) IV ☐ 40 mg, ☐ 125 mg, ☐ other ________mg

☐ Benadryl (diphenhydramine) ________mg ☐ PO ☐ IV

☐ Other: ____________

☐ Zyrtec (cetirizine) 10mg PO

☐ Claritin (loratadine) 10mg PO

LABORATORY ORDERS

☐ CBC w/ DIFF ☐ each infusion

☐ CRP ☐ each infusion

☐ CMP ☐ each infusion

☐ ESR ☐ each infusion

☐ Hepatic Panel ☐ each infusion

☐ Renal Panel ☐ each infusion

☐ Quantiferon TB (annually)

☐ Other: ____________

☐ Other: ____________

☐ Other: ____________

☐ Other: ____________

☐ Other: ____________

☐ Other: ____________

☐ Other: ____________

Due: ____________

PRESCRIBER'S INFORMATION

Prescriber Name: ____________

License #: ____________ NPI: ____________ DEA: ____________

Address: ____________

City: ____________ State: ________ Zip: ________

Office Contact: ____________

Office Phone: ____________ Office Fax: ____________

Prescriber's Signature: ____________