Jean Walter Infusion Center - Infusion Therapy Order

www.JeanWalterInfusion.com
Phone: 443-354-3772 Fax:443-354-3767

Patient Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

Allergies : _____ Height & Weight: _____

Referring Provider: _____ NPI/DEA: _____

Specialty: _____

Infusion Medication:

- ☐ Actemra
- ☐ Benlysta
- ☐ Cinqair
- ☐ Entyvio
- ☐ Iron (Fereheme)
- ☐ Krystexxa
- ☐ Ocrevus
- ☐ Remicade/Biosimilar
- ☐ Rituxan/Biosimilar
- ☐ Simpori Aria
- ☐ Tysabri
- ☐ Skyrizzi
- ☐ Solaris
- ☐ Saphnelo
- ☐ Reclast
- ☐ Orencia
- ☐ Stelara
- ☐ Vyepti

Injections:

- ☐ Boniva
- ☐ Cimzia
- ☐ Nucala
- ☐ Prolia
- ☐ Stelara
- ☐ Taltz
- ☐ Vyvgart
- ☐ Fasenra
- ☐ Ilumya
- ☐ Tezspire
- ☐ Evenity
- ☐ Leqvio
- ☐ Xolair
- ☐ _____

IVIG:

- ☐ Gammagard (10%)
- ☐ Privigen (10%)
- ☐ _____

Administer: ☐ IV ☐ Sub-Q

Maintenance:

- ☐ ____ gm/kg divided over ___ days every ___ weeks x12 months
- ☐ ____ grams divided over ___ days every ___ weeks x12 months
- ☐ Other: _____
- ☐ Infuse dose over ____ hours or per manufacturer guidelines

Preferred product _____ ☐ No product preference

PICC/ Port Line: Yes or No **Diagnosis W/ ICD 10:** _____

Frequency: _____

Initial Dose: _____

Maintenance: _____

Number of Refills: _____

Please indicate if additional labs are required at time of infusion:

_____

Please indicate if any premedication is required:

☐ Tylenol ☐ Benadryl ☐ Other: _____

Documentation Needed:

☐ Insurance Cards ☐ Most recent clinical including H&P and Labs ☐ Progress notes

☐ Contact information for the ordering provider ☐ Medication List ☐ Benefits Investigation

Provider Signature: _____ **Date:** _____