

**Patient Information**

Patient Name:		DOB:	
Patient Home Phone:	Patient Cell Phone:	Patient Email:	
Emergency/Alternate Contact Name:		Emergency/Alternate Contact Phone:	
NKDA	Allergies:	Weight lbs/kg:	Height:
Patient Status:	New to Therapy	Continuing Therapy	Therapy Change
			Last infusion date (if applicable): _____
Is the patient pregnant, planning a pregnancy or nursing:		Yes	No
		Does the patient need interpreter services:	
		Yes	No

**Provider Information**

Referral Coordinator Name:		Referral Coordinator Email:	
Ordering Provider:		Provider NPI:	
Referring Practice Name:		Phone:	Fax:
Practice Address:		City:	State: Zip:

**ICD-10 CODE**
**Medication Order**
**Avastin** (bevacizumab)

**Dose and frequency:**      5mg/kg (\_\_\_\_mg) IV every 2 weeks      7.5mg/kg (\_\_\_\_mg) IV every 3 weeks  
    10mg/kg (\_\_\_\_mg) IV every 2 weeks      15mg/kg (\_\_\_\_mg) IV every 3 weeks

Other: \_\_\_\_\_

**Documentation Required (Note: Send all labs, must include specific labs listed here)**

Labs (urinalysis)	Insurance Card (front and back)	Current Medications	History/Progress Notes
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**Pre-Medication Order** *(given 30 min before each infusion)*

<b>acetaminophen</b> (Tylenol)	500mg	650mg	1000mg PO	<b>diphenhydrAMINE</b> (Benadryl)	25mg	50mg /	PO	IV
<b>cetirizine</b> (ZyrTEC)	10mg PO			<b>methylPREDNISolone</b> (SOLU-Medrol)	40mg IV	125mg IV		
<b>loratadine</b> (Claritin)	10mg PO			<b>hydrocortisone</b> (Solu-CORTEF)	100mg IV			
<b>ondansetron</b> (Zofran)	4mg	8mg /	PO IV					

Other: \_\_\_\_\_

Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Frequency: \_\_\_\_\_

**Line/Port Use Orders**

RN to start/discontinue peripheral IV or access/de-access port  
 RN to administer 3-10 mL normal saline with heparin 100 units/mL 1-5 mL per SASH method  
 Do NOT administer heparin to this patient  
 Additional orders: \_\_\_\_\_

**Adverse Reaction and Anaphylaxis Orders**

Standard anaphylaxis kit (EPINEPHrine 0.3 mg IM PRN for severe reactions x 1, may repeat once within 5-15 minutes for a maximum of 2 doses;  
 Benadryl 50 mg PO PRN for mild-moderate reactions x 1; Benadryl 50 mg IV PRN for mild-moderate reactions x 1)  
 Additional orders: \_\_\_\_\_

**Special Instructions (Prior therapy, treatment dates, and reasons for d/c)**
**Provider Name**

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.

o 818.390.9696 aleraicare.com

**Provider Signature**
**Date**

Check here if this is a stat order

advanced home infusion™