

(Zinpalva)

Provider Order Form rev. 3/7/23



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PATIENT INFORMATIONReferral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date:	Patient Name:	DOB:
ICD-10 code (required):		
ICD-10 description:		
☐ NKDA Allergies:	Weight (lbs/kg):	Height:
Patient Status: ☐ New to Therapy ☐ Continuing Therapy	Last Treatment Date:	Next Due Date:

PROVIDER INFORMATION

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

NURSING

- 0 TB status & date (list results here & attach clinicals) _____
- 0 Provide nursing care per 360 Infusion Center Nursing Procedures, including reaction management and post-procedure observation

LABORATORY ORDERS

- ☐ CBC ☐ at each dose ☐ every _____
- ☐ CMP ☐ at each dose ☐ every _____
- ☐ CRP ☐ at each dose ☐ every _____
- ☐ Other: _____

PRE-MEDICATION ORDERS

- ☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
- ☐ cetirizine (Zyrtec) 10mg PO
- ☐ loratadine (Claritin) 10mg PO
- ☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
- ☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV
- ☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
- ☐ Other: _____
- Dose: _____ Route: _____
- Frequency: _____

SPECIAL INSTRUCTIONS**THERAPY ADMINISTRATION**

- ☐ **Zinpalva:**
- Dose: ☐ 10mg/kg
 - Administer ☐ IV ☐ other
 - ☐ Other
 - Frequency: ☐ every week / ☐ every 2 weeks / ☐ other: _____

Provider Name (Print)_____
Provider Signature_____
Date