# BIOCARE INFUSION
ONCOLOGY & THERAPEUTICS

# ONCOLOGY ORDER FORM

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## PATIENT INFORMATION:

Patient Name: _____ DOB: _____ Phone: _____

## MEDICAL INFORMATION

**ICD-10 code**: _____ **Diagnosis**: _____

Allergies: _____

Weight: _____ **kg** Height: _____ inches BSA: _____ $m^2$ *(if applicable)*

☐ Call for weight change greater than 10% from baseline

☐ No dose modifications required for any weight change

## LAB ORDERS OR OTHER TESTS RELATED TO TREATMENT

| | | |
|---|---|---|
| ☐ CBC w/plts, diff | ☐ TSH | ☐ LVEF done: _____/Ejection fraction: _____% |
| ☐ CMP | ☐ Creatinine | ☐ Urine pregnancy test |
| ☐ LFTs | ☐ Renal Function | ☐ Other: _____ |

Lab frequency: ☐ Prior to each cycle ☐ Other: _____

Labs to be drawn by: ☐ Infusion Center ☐ Referring Provider

## HOLD PARAMETERS - PLEASE INDICATE

☐ No hold parameters for ANC/Platelets

☐ No hold parameters

☐ Hold and call for LFTs 3x ULN and/or Bili 1.5x ULN

☐ Hold and call for creatinine 1.5x ULN

☐ Hold and call for ANC: _____ /Platelets: _____

☐ Other hold parameters: _____

## PRE-MED AND ANTIEMETIC ORDERS

| | | | |
|---|---|---|---|
| ☐ Zofran _____ mg IV | ☐ Decadron _____ mg IV | ☐ Benadryl _____ mg IV | ☐ Pepcid _____ mg IV |
| ☐ Reglan _____ mg IV | ☐ Solu-Medrol _____ mg IV | ☐ Benadryl _____ mg PO | ☐ Tylenol _____ mg PO |
| ☐ Granisetron _____ mg IV | ☐ Hydration/other: _____ | Frequency: ☐ PRN ☐ Standing order ☐_____ | |

## TREATMENT ORDER

**** All available drugs listed on Page 2****

| Date/Day | Drug | Dosing (i.e., mg/kg) | Calculated Dose | Route | Frequency | Special Instructions *Volume, diluent, & rate set by Biocare Infusion unless otherwise noted here |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

Date of last infusion: _____ Cycle number: _____

Subsequent treatments may be given +/- _____ days

This order is good for _____ cycles from the date ordered. Next appointment with Oncologist: _____

Call referring provider for: _____

Oral treatment patient is on: _____

Other orders/information: _____

## PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing *Biocare Infusion,* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

## PREFERRED LOCATION

City: _____ State: _____ *View our locations here:*

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# COMPREHENSIVE SUPPORT FOR ONCOLOGY THERAPY

## PATIENT INFORMATION:

Patient Name: _____ DOB: _____

## REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- ☐ Patient demographics including insurance information (copies of insurance cards preferred)
- ☐ Treatment orders - include drugs, dose, frequency, administration, and cycle definition
- ☐ Pre-medication orders (including glucocorticoids) - *if applicable*
- ☐ Supportive therapy orders (including anti-emetics, CSFs, hydration, antibiotics) - *if applicable*
- ☐ Note: Oral prescriptions needs to filled at local pharmacy prior to infusion
- ☐ Monitor and hold parameter
- ☐ Dose adjustment protocol, where applicable (i.e., weight changes, lab parameters)
- ☐ Standing orders (infusion reactions, management of CVC occlusion, etc.)
- ☐ Lab orders - if labs need to be drawn by Biocare Infusion
- ☐ Clinical chart notes within the last 12 month
- ☐ Recent lab results & diagnostic results
- ☐ medication list, if available
- ☐ Date of last cycle or infusion dose
- ☐ Next follow-up visit with Oncologist)

**Oncology Therapies Available:**

| | | |
|---|---|---|
| ado-trastuzumab* | fam-trastuzumab* | pemetrexed* |
| amivantamab | fulvestrant* | pertuzumab* |
| bevacizumab & biosimilars | ipilimumab | pertuzumab/trastuzumab/hyaluronidase* |
| bortezomib* | lantreotide | rituximab & biosimilars |
| brentuximab vedotin* | leuprolide acetate | sirolimus* |
| daratumumab & hyaluronidase | loncastuximab* | tisotumab vedotin* |
| denosumab | octreotide | trastuzumab & biosimilars |
| dostarumab | pegfilgrastim | triptorelin pamoate* |
| durvalumab | pembrolizumab | |

*only available at certain locations

Biocare Infusion will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

**Please fax all information to (470) 922-3656 or call (470) 377-6400 for assistance**