Cumberland Vital Care
Fax Referral To:
(931) 456-4857
Direct Phone: (931) 456-0680

KIMYRSA ORDER FORM

Date: Patient Name: Date of Birth:	ICD-10 Code: _____ Allergies: _____ Weight: _____lbs OR _____kg

Therapy Status	Provider Information
☐ New Start ☐ Continuing Therapy: Last Dose: _____	Ordering Provider: _____ Provider NPI: _____ Provider Phone: _____ Provider Fax: _____ Provider Address: _____

MEDICATION ORDER

Kimyrsa	✓ Kimyrsa 1,200mg IV x one dose over one hour per protocol. ✓ The use of unfractionated heparin sodium is contraindicated for 120 hours (5 days) after Kimyrsa administration

PRE-MEDICATIONS

Oral	IV
☐ Acetaminophen: ___325mg ___500mg __650mg ☐ Loratadine: 10 mg ☐ Cetirizine: 10mg ☐ Diphenhydramine: ___25mg ___50mg ☐ Famotidine: ___20mg ___40mg ☐ Ibuprofen: ___200mg ___400mg ___600mg ☐ Ondansetron: ___4mg ___8mg ☐ Other_____	☐ Dexamethasone: ___4mg ___8mg ☐ Diphenhydramine: ___25mg __50mg ☐ Famotidine: ___20mg ___40mg ☐ Methylprednisolone 125mg ☐ Hydrocortisone 100mg ☐ Ondansetron: ___4mg ___8mg ☐ Other_____

LAB ORDERS (Please indicate any labs to be drawn and frequency)	OTHER REQUIRED DOCUMENTATION
Surveillance lab ordering, and monitoring is the responsibility of the prescriber	(Please fax this signed order form, along with the following documents to 800-223-4063) • History & Physical, Last Ofice Visit Note • Patient Demographics and Insurance Information • Medication List • Recent Lab Work

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

Dispense as Written: _____ _____ Prescriber Name Date	Substitution Allowed: _____ _____ Prescriber Name Date

V 10.5.22