Orbactiv Enrollment Form

Date: _____
Patient Name: _____
Date of Birth: _____

Cumberland Vital Care
Fax Referral To:
(931) 456-4857
Direct Phone: (931) 456-0687

CVC CUMBERLAND VITAL CARE
PHARMACEUTICAL COMPOUNDING & INFUSION SERVICES

PREVIOUS ADMINISTRATION

If YES, please provide the following information:	If NO, please indicate desired location for first dose:
Last Infusion Date: _____ Next Infusion Date: _____	☐ Physician's Office TwelveStone Infusion Center: ☐Canton ☐Chattanooga ☐Knoxville ☐Mount Juliet ☐Murfreesboro ☐ Other: _____ Desired Start Date: _____

DIAGNOSIS

Description	*ICD-10 Code*
☐ Acute bacterial skin and soft tissue infection ☐ Other:_____	☐ L08.9 ☐ Other: _____

OTHER REQUIRED DOCUMENTATION *(Please attach documents as needed)*

☐ This signed order form
☐ History and Physical
☐ Patient Demographics and Insurance Information
☐ Clinical progress notes, lab work (including most recent renal function tests and any other tests supporting primary diagnosis)
☐ Tysabri Touch Enrollment

CLINICAL INFORMATION *(Please attach all clinical information, lab results and other medical history documents)*

Patient Weight: _____ lbs/kg Height: _____ Inches/CM BSA : _____ Allergies: _____

Line Access: ☐ PIV ☐ PICC (SL DL TL) ☐ PORT (Huber size_____Gauge_____Length) ☐ Sub-Q

MEDICATION	DIRECTIONS	REFILLS	BASELINE LABWORK REQ'D TO INITIATE (Check for TwelveStone to draw)
☐ Orbactiv	☐ Infuse 1200mg IV over a minimum of 3 hours x 1 dose		☐ CBC w/Differential

LAB ORDERS - To be drawn by TwelveStone

Order	Frequency
CBC w/Differential	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q____Weeks ☐ Other_____
CBC w/o Differential	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q____Weeks ☐ Other_____
CMP	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q____Weeks ☐ Other_____
BMP	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q____Weeks ☐ Other_____
CRP	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q____Weeks ☐ Other_____
Sed Rate	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q____Weeks ☐ Other_____
Calcium	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q____Weeks ☐ Other_____
Tb QuantiFERON Gold	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q____Weeks ☐ Other_____
Hepatitis Panel	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q____Weeks ☐ Other_____
Other_____	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q____Weeks ☐ Other_____

PRE-MEDICATIONS/No Pre-meds please check here _____

Oral	IV
Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg	Dexamethasone: ☐ 4mg ☐ 8mg
Cetirizine: ☐ 10mg	Diphenhydramine: ☐ 25mg ☐ 50mg
Diphenhydramine: ☐ 25mg ☐ 50mg	Famotidine: ☐ 20mg ☐ 40mg
Famotidine: ☐ 20mg ☐ 40mg	Methylprednisolone: ☐ _____mg IV over _____ mins
Ibuprofen: ☐ 200mg	Ondansetron: ☐ 4mg ☐ 8mg
Loratidine: ☐ 10mg	
Ondansetron: ☐ 4mg	

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

Physician's Phone #	Physician's NPI#	Physician's Fax #	Physician's Address
Dispense as Written	Date	Substitution Allowed	Date

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