Zemdri Enrollment Form

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

Cumberland Vital Care
Fax Referral To:
(931) 456-4968
Direct Phone: (931) 456-0680

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*
☐ Complicated Urinary Tract Infection ☐ Pyelonephritis ☐ Other	☐ N39.0 ☐ N10 ☐ 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)

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

Patient Weight: : 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)
☐ Pharm.D to dose ☐ Zemdri	☐ CLcr = 90 or > (ml/min) - Infuse 15mg/kg (_____ mg) IV over 30 minutes every 24 hours x ____ days. ☐ CLcr = 60-89 (ml/min) - Infuse 15mg/kg (_____ mg) IV over 30 minutes every 24 hours x _____ days. ☐ CLcr = 30-59 (ml/min) - Infuse 10mg/kg (_____ mg) IV over 30 minutes every 24 hours x _____ days. ☐ CLcr = 15-29 (ml/min) - Infuse 10mg/kg (_____ mg) IV over 30 minutes every 48 hours x _____ days.		☐ CBC w/Differential ☐ BMP or Renal Panel ☐ Culture and Sensitivity

LAB ORDERS - To be drawn by TwelveStone - *Recommended

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 X 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 - *RECOMMENDED/Check Here if NO Pre-Meds _____

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