AVANT Wellness, PLLC

Adakveo Referral Form

Please fax completed referral form to Avant Wellness, PLLC
(980)446-1445
Please contact office for questions:
(980)446-1444

PATIENT DEMOGRAPHICS:

PATIENT NAME:
DATE OF REFERRAL:
SOCIAL SECURITY NUMBER:
DATE OF BIRTH:
PREFERRED CONTACT #:
SECONDARY CONTACT #:
ADDRESS:
CITY, STATE, ZIP:

PRIMARY DIAGNOSIS: PLEASE PROVIDE ICD-IO CODE:

- ☐ D57.0 - Hb-SS disease
- ☐ D57.2 - Sickle cell/Hb-C disease
- ☐ D57.4 - Sickle cell thalassemia
- ☐ D57.8 - Other sickle cell disorders
- ☐ D64.9 - Anemia
- ☐ Other: _____ - _____

PATIENT INFORMATION:

ALLERGIES: ☐ NKDA

HEIGHT: ____ Ft ____ In WEIGHT: ____ Lb or ____ Kg

GENDER: ☐ F ☐ M

FIRST DOSE: ☐ Y ☐ N

DATE OF LAST INFUSION:

NEXT DOSE DUE BY:

ACCESS/LINE TYPE: ☐ PIV ☐ PORT ☐ PICC ☐ MIDLINE

OTHER:

REQUIRED DOCUMENTATION: PLEASE PROVIDE A COPY OF THE FOLLOWING DOCUMENTS

☐ 1. INSURANCE CARD (Front & Back) ☐ 2. MOST RECENT LABS ☐ 3. PATIENT DEMOGRAPHICS ☐ 4. H & P

PHYSICIAN ORDER:

DRUG: ☐ ADAKVEO® crizanlizumab-tmca FOR IV INFUSION • 10 mg/mL

DOSE: ☐ 5mg/kg IV over 30 minutes on Week 0, 2 & every 4 weeks therafter.

REFILL: ☐ 1 year ☐ _____

IRON DEFICIENCY:

INJECTAFER:

- ☐ 750mg IV on day 0 & 7 (for patients >50kg)
- ☐ 15mg/kg IV on day 0 & 7 (for patients <50kg); max 1500mg
- ☐ Other (specify): _____

FERAHEME:

- ☐ Administer 510 mg and repeat after 3 to 8 days later

VENOFER:

- ☐ 100 mg in 100ml NSS over 15 minutes
- ☐ 200 mg in 100ml NSS over 15 minutes

OTHER:

- ☐ Toradol _____ mg PO or IVP or IM
- ☐ 0.5 NSS _____ mL/hour or IVP

PRN & PREMEDICATIONS:

MEDICATIONS	30 minutes prior every infusion	PRN
Acetaminophen ____ mg PO		
Diphenhydramine ____ mg PO		
Methylprednisolone ____ mg IV push over 5 minutes		
Epinephrine 0.3mg IM once		

MEDICATION WASTE:

Authorized to round up to nearest vial size?
☐ YES ☐ NO

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

☐ ADMINISTER ACUTE INFUSION AND ANAPHYLAXIS MEDS PER GREENHILL INFUSION POLICY AND PROCEDURE

PRESCRIBER INFORMATION:

PHYSICIAN NAME: _____
OFFICE CONTACT: _____
PHONE: _____
FAX: _____
ADDRESS: _____
CITY, STATE, ZIP: _____
LICENSE #: _____
NPI: _____

PHYSICIAN SIGNATURE: _____
DATE: _____