Pombiliti

Treatment Location: _____

PROVIDERS: Please include the following to expedite the order:
Patient Demographics, Most Recent Office Visit Note, Insurance Information

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: Patient Phone: DOB:

ICD-10 code (required): ☐ E74.02 ICD Description:

Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

NURSING

- ☑ Center will use Hypersensitivity protocol established by Infusion for Health and PI
- ☑ Patients must be prescribed Opfolda in combination with Pombiliti

PRE-MEDICATION ORDERS

Consider pretreating with antihistamines, antipyretics, and/or corticosteroids.

- ☐ Diphenhydramine ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
- ☐ Acetaminophen ☐ 325mg / ☐ 500mg / ☐ 650mg PO
- ☐ SoluMedrol (methylprednisolone) ☐ 40mg / ☐ 125mg IV

Other: _____

Dose: _____ Route: _____ Frequency: _____

SPECIAL INSTRUCTIONS:

LABORATORY ORDERS

- ☐ CBC ☐ at each dose ☐ every _____
- ☐ CMP ☐ at each dose ☐ every _____
- ☑ Urine Pregnancy ☐ at each dose ☐ every _____
- ☐ Other: _____ ☐ Frequency:
- ☐ Please check this box if you DO NOT authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

THERAPY ADMINISTRATION

- ☑ Pombiliti Intravenous Infusion
  - ☑ Dose: 20 mg/kg IV infusion every other week over approximately 4 hours **Total Dose:** _____ mg
    - Confirm patient has been fasting for 2 hours prior to taking oral Opfolda and for 2 hours after taking oral Opfolda
    - Initiate Pombiliti Infusion approximately 1 hour after oral administration of Opfolda
    - Reschedule Pombiliti Infusion at least 24 hours after Opfolda was last taken if Pombiliti cannot be started with 3 hours of oral administration of Opfolda.
- ☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
  (if not indicated order will expire one year from date signed)

To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, I4H is authorized to administer a generic or biosimilar.

Provider Name (Print) Provider Signature Date

☐ ***Please check this box if you DO NOT authorize Infusion for Health to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.***