HEMATOLOGY
ONCOLOGY
ASSOCIATES *of*
FREDERICKSBURG

Referral For Specialty, Non-Oncology Medications

Thank you for entrusting our office (HOAF) to administer your patient's injectable or infusible medication(s). Please complete the following order form and specify the medications for treatment.

THIS FORM MUST BE FILLED OUT IN ITS ENTIRETY and ATTACHED DOCUMENTATION REQUIRED MUST BE RECEIVED IN ORDER TO SCHEDULE PATIENT.

NEW ORDERS AND SUPPORTIVE DOCUMENTATION IS REQUIRED EVERY 6 MONTHS IN ORDER TO CONTINUE SCHEDULING PATIENTS AT HOAF.

Patient's Name _____ Date of Birth _____

Gender (circle) Identifies as: M F

Patient Phone # _____ HEIGHT Circle units: _____ IN CM

Diagnosis & ICD 10 _____ WEIGHT Circle units: _____ LBS KG

ALLERGIES _____

ITEMS REQUIRED with TREATMENT ORDERS:

- Patient demographics with insurance information
- Most recent progress note w/current medication list (if patient has CHF, need classification, cardiac clearance and/or ECHO)
- Past treatments or failures of previous treatment (REASON: our office will assist with obtaining prior authorization and requires this information when speaking with insurance companies). This can be included in a progress or visit note.
- Consent for treatment with above mentioned drug/treatment.
- Additional testing and labs for certain medications as outlined in the list below

Indication and Orders (please attach specific orders or fill in completely below):

- Provide drug name, dosing, dosing interval, administration instructions and duration of treatment for all medications to be given. Include any pre-medications needed.
- You must answer Yes (Y) or No (NO) if generic or biosimilar is acceptable, or if brand must be used.
- If this is not a first dose, please indicate the last treatment given to ensure proper scheduling.

HOAF needs to confirm that we can obtain and/or administer the medication(s) before accepting your patient. Please provide the best contact at your practice and phone number below.

HEMATOLOGY
ONCOLOGY
ASSOCIATES *of*
FREDERICKSBURG

PRETREATMENT LABS, TESTING, MONITORING AND SUBSEQUENT DOSING CHANGES ARE THE FULL RESPONSIBILITY OF THE ORDERING PROVIDER

✓HOAF staff can collect the required labs, if you include them on this order form.

✓Lab results will be sent to the ordering provider and will NOT be reviewed or managed by HOAF Providers or Staff.

MEDICATION NAME(S)	DOSE and INTERVAL	DIRECTIONS/SIG including DURATION OF TREATMENT	BIOSIMILAR or GENERIC ACCEPTABLE (MUST CHECK ONE)	DATE OF LAST TREATMENT
_____	_____	_____	❑ Yes	_____
_____	_____	_____	❑ No	_____
_____	_____	_____		_____
_____	_____	_____		_____

LABORATORY ORDERS TO BE DRAWN AT HOAF PRIOR TO TREATMENT (SPECIFY TIMING OF LABS)
(NOTE: HOAF STAFF WILL NOT MANAGE LAB RESULTS BUT WILL ENSURE ORDERING PROVIDER IS COPIED)
IF LABS ARE TO BE DRAWN OUTSIDE OF HOAF, PLEASE PROVIDE THESE RESULTS, OR ASK PATIENT TO BRING A COPY.

_____

By signing this treatment order, you attest that the patient has been recently assessed, and that all pretreatment labs, testing/ immunizations have been completed to the best of your knowledge, and this treatment is on label and appropriate for the above patient. You also understand that any changes to treatment are your sole responsibility and must be communicated to HOAF prior to patients' appointment.

Ordering Provider Signature: _____ Date: _____

Provider Name (Print): _____

Best Contact Name and Number(s) for your Practice: _____

HEMATOLOGY
ONCOLOGY
ASSOCIATES *of*
FREDERICKSBURG

DRUG SPECIFIC TESTING and FOLLOW UP:

In addition to the items needed above, for specific medications, please submit additional records for the specific drugs below. These results must be received prior to scheduling the patient for treatment.

- For **Leqvio**, recent laboratory cholesterol testing (within 3 months) and concomitant anti-lipid medications.
  IF USING LEQVIO ORDER FORM PLEASE FILL IT OUT IN ITS ENTIRETY and INCLUDE CONSENT FOR TREATMENT
- For **Evenity** injections, proof of DEXA scan within the past 2 years showing osteoporosis (T score less than 3.0 or recent fracture) and serum calcium level within 2-4 weeks of next injection.
- For **Prolia** injections, proof of DEXA scan within past 2 years showing osteoporosis, and a serum calcium level within 2-4 weeks of next injection.
- For **Reclast** injections, proof of DEXA scan within past 2 years showing osteopenia or osteoporosis and a CMP within 2-4 weeks of infusion.
- For **rituximab, infliximab, their biosimilar drugs,** and other drugs requiring: Proof of negative HIV, Hepatitis B and C testing, negative HBV titer.
- For infliximab, a negative TB test with date of last testing or proof of treated latent TB (within months)
- For **Leqembi** (lecanemab), proof of MRI will be required, along with confirmation of subsequent MRIs completed prior to cycles 5, 7 and 14. Please submit schedule of follow up appointments with your office.
- For **Soliris** or **Ultamiris**, record of meningococcal vaccine as recommended by prescribing information.