

Zemdri Enrollment Form

TwelveStone Health Partners

**Fax Referral To:
(800) 223-4063**



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

Direct Phone: (615) 278-3350
Toll Free: (844) 893-0012

PREVIOUS ADMINISTRATION

If YES, please provide the following information:

Last Infusion Date: _____
Next Infusion Date: _____

If NO, please indicate desired location for first dose:

Physician's Office
TwelveStone Infusion Center:
 Canton Chattanooga Knoxville Mount Juliet Murfreesboro
 Other: _____
Desired Start Date: _____

DIAGNOSIS

Description

Complicated Urinary Tract Infection Pyelonephritis Other

ICD-10 Code

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	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
CBC w/o Differential	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
CMP	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
*BMP	<input type="checkbox"/> One Time Prior to Treatment <input checked="" type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
CRP	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
Sed Rate	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
Calcium	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
Tb QuantiFERON Gold	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
Hepatitis Panel	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
Other _____	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____

PRE-MEDICATIONS - *RECOMMENDED/Check Here if NO Pre-Meds _____

Oral

IV

Acetaminophen: <input type="checkbox"/> 325mg <input type="checkbox"/> 500mg <input type="checkbox"/> 650mg	Dexamethasone: <input type="checkbox"/> 10mg
Cetirizine: <input type="checkbox"/> 10mg	Diphenhydramine: <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg
Diphenhydramine: <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg	Famotidine: <input type="checkbox"/> 20mg <input type="checkbox"/> 40mg
Famotidine: <input type="checkbox"/> 20mg <input type="checkbox"/> 40mg	Methylprednisolone: <input type="checkbox"/> _____mg IV over _____ mins
Ibuprofen: <input type="checkbox"/> 200mg	Ondansetron: <input type="checkbox"/> 4mg <input type="checkbox"/> 8mg
Loratadine: <input type="checkbox"/> 10mg	
Ondansetron: <input type="checkbox"/> 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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