

Cyanocobalamin (Vitamin B-12)

Along with this order form, please include the following: Demographics, Insurance Information, Lab Results, Current Medications, and Recent Visit Notes. ArrIVE Infusion will obtain any necessary medication authorizations for patients receiving infusion therapies.

Order Date: ____/____/____

Referral Status: ☐ New Referral ☐ Dose or Frequency Change ☐ Renewal

Patient Name: _____ Patient Address: _____ Patient Phone Number: _____ Date of Birth: ____/____/____ Weight: ____ kg Height: ____ cm Allergies: _____		Primary Insurance: _____ Member ID: _____ Secondary Insurance: _____ Member ID: _____			
Diagnosis <input type="checkbox"/> Vitamin B-12 deficiency anemia (D51.0-D51.9) <input type="checkbox"/> Unspecified deficiency anemia (D53.9) <input type="checkbox"/> Deficiency of other specified B group vitamins (E53.8) <input type="checkbox"/> Alcohol-induced chronic pancreatitis (K86.0) <input type="checkbox"/> Personality change due to known physiological condition (F07.0) <input type="checkbox"/> Hereditary and idiopathic peripheral neuropathy, unspecified (G60.9) <input type="checkbox"/> Polyneuropathy in diseases classified elsewhere (G63) <input type="checkbox"/> Vascular dementia (F01.50, F01.51) <input type="checkbox"/> Other Diagnosis Code (ICD-10): _____ <input type="checkbox"/> Other Indication: _____ Target start date: _____		Labs <input type="checkbox"/> CMP <input type="checkbox"/> CBC w/diff <input type="checkbox"/> CBC w/o diff Frequency <input type="checkbox"/> Every infusion <input type="checkbox"/> Other: _____			
Cyanocobalamin (Vitamin B-12) Nursing note: must be given as an intramuscular injection					
Dose <input type="checkbox"/> 1,000 mcg <input type="checkbox"/> _____ mcg		Frequency <table border="0"> <tr> <td> Induction <input type="checkbox"/> every day for _____ days <input type="checkbox"/> every week for _____ weeks </td> <td> Maintenance <input type="checkbox"/> Every 4 weeks <input type="checkbox"/> Every _____ weeks </td> </tr> </table> Date of last injection: ____/____/____		Induction <input type="checkbox"/> every day for _____ days <input type="checkbox"/> every week for _____ weeks	Maintenance <input type="checkbox"/> Every 4 weeks <input type="checkbox"/> Every _____ weeks
Induction <input type="checkbox"/> every day for _____ days <input type="checkbox"/> every week for _____ weeks	Maintenance <input type="checkbox"/> Every 4 weeks <input type="checkbox"/> Every _____ weeks				

An Outpatient Department of Trinity Health Oakland
9406 Village Place Blvd, Brighton, MI 48116
Phone: 810-844-7373
Fax: 810-844-7366

Pre-Medications and Pre-Protocol (ordered at physician discretion)	<input type="checkbox"/> Acetaminophen 650 mg PO once <input type="checkbox"/> Loratadine 10 mg PO once <input type="checkbox"/> Diphenhydramine once <input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg <input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> Famotidine 20 mg IV once <input type="checkbox"/> Hydrocortisone 100 mg IV once <input type="checkbox"/> Methylprednisolone 125 mg IVP once <input type="checkbox"/> Other: _____	Hydration <input type="checkbox"/> LR <input type="checkbox"/> Sodium Chloride 0.9% <input type="checkbox"/> Other _____ _____ mL at _____ mL/hr <input type="checkbox"/> Before <input type="checkbox"/> During <input type="checkbox"/> Following
Flushing Protocol <i>as needed for line care</i>	<input type="checkbox"/> Sodium Chloride 0.9% <input type="checkbox"/> 5 mL <input type="checkbox"/> 10 mL	Heparin 100 Units/mL <input type="checkbox"/> 5 mL <input type="checkbox"/> 10 mL
Hypersensitivity Panel Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy as necessary	<ul style="list-style-type: none"> • Sodium chloride 0.9% bolus 500 mL once as needed for hypotensive management (SBP <90mmHg) • Acetaminophen 650 mg once as needed for temperature GREATER than 38 C (100.4 F), headaches, generalized pain, back pain, abdominal cramping • Albuterol 2.5 mg /3 mL (0.083%) nebulizer solution 2.5 mg, nebulize every 10 min PRN, hypoxemia, bronchospasm, wheezing, dyspnea, for 2 doses • Albuterol HFA inhaler 2 puffs q4hs as needed for hypoxemia, bronchospasm, wheezing, dyspnea • Epinephrine injection 0.3 mg IM every 15 minutes as needed for SBP less than 90mmHg, mild to moderate anaphylaxis for 3 doses • Famotidine injection 20 mg IV over 2 minutes once as needed for severe hypersensitivity/infusion reaction including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure • Diphenhydramine injection 25 mg IV over 1 minute once as needed, moderate hypersensitivity/infusion reaction (grade 2) including temperature greater than 100.5, rigors, localized rash/hives, vomiting, nausea, pruritis, flushing, dizziness, back pain, abdominal cramping, uneasiness, agitation, feeling of impending doom • Diphenhydramine injection 50 mg IV over 1 minute once as needed for severe hypersensitivity/infusion reaction (grade 3), including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure • Hydrocortisone sodium succinate injection 100 mg IV once as needed for severe hypersensitivity/infusion reaction (grade 3), including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure 	
<div> <div> Provider Name: _____ Attending Physician Name: _____ Office Phone Number: _____ </div> <div> Provider Signature: _____ Provider NPI: _____ Office Fax Number: _____ </div> </div> <p><i>Note: This order is valid for 12 months from date of physician signature.</i></p>		