

Epogen/Procrit/Retacrit Injection Orders

Patient Name: _____ DOB: _____ Male Female

Diagnosis (please provide ICD10 code) _____

Secondary Diagnosis: _____ NKDA Allergies: _____

New Start Therapy Continuation of Therapy Date of last dose (if applicable): _____

Ordering Provider:

Provider NPI: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

EPOGEN/PROCRI/RETACRIT ORDERS:

- 2,000 units
- 4,000 units
- 10,000 units

Inject subcutaneously

- x 1 occurrence
- every ____ weeks/months (please specify)
- other:

REQUIRED TESTING/LABS:

- Clinical/Progress Notes supporting primary diagnosis (please attach)
- Recent Labs: CBC, Iron Studies (please attach):

REFILLS:

**Based on product availability and patient insurance requirements, product recommendations may be provided*

Sage Infusion Standing Orders:

- Provide treatment under Sage Infusion's Clinical Guidelines, Medication Safety Protocol, Emergency Guidelines, and Action Plan for Infusion Reactions.

Provider Name

Provider Signature

Date