Lane Regional Medical Center

Care You Can Count On

INFUSION CENTER ORDERS

Name: _____ D.O.B.: _____

Allergies: _____

Phone Number (1st): _____ 2nd: _____

Height: _____ Weight in Kilograms: _____

Diagnosis/code:

Primary: _____ Secondary: _____

Insurance Information (attach copies of insurance cards)

Authorization number: _____ Insurance Contact Person: _____

Primary Insurance: _____

Group Number: _____ Policy Number: _____

Secondary Insurance: _____

Group Number: _____ Policy Number: _____

Orders:

Labs: _____

Premeds/Medications	Dose	Route	Frequency	Start Date	Stop Date
Casirivimab	600 mg	IV	x1		
Imdevimab	600 mg	IV	x1		

Others: Mix both medications together in Sodium Chloride 0.9% 100ml.

Infuse over at least 30 minutes via pump or gravity.

Monitor for at least 1 hour post infusion.

_____

_____

_____

Physician Signature Date & Time

*Please fax progress notes/lab results supporting medical necessity

LMH INFCNO

LRMC 1595
HAC:3/12
MEC:4/12