Local Infusion

MYLOCALINFUSION.COM

ZOLADEX (GOSERELIN IMPLANT 3.6 MG/10.8 MG) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____
Mobile Number: _____ Patient Weight: _____kg
Allergies: _____
☐ Patient has known difficult venous access. Comments:_____

DIAGNOSIS (Provider must specify)

☐ Locally Confined Prostate Cancer (with flutamide), ICD 10: C61
☐ Advanced Prostate Cancer, ICD 10: C61
☐ Endometriosis, ICD 10: N80.9
☐ Dysfunctional Uterine Bleeding – Endometrial Thinning Prior to Endometrial Ablation, ICD 10: N93._____
☐ Advanced Breast Cancer (Pre-/Perimenopausal), ICD 10: C50.9_____
☐ Other:_____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI:_____
Signature: _____ Date: _____
Contact Name: _____ Phone: _____ Fax: _____
Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:
☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION (Not typically indicated)

☐ Acetaminophen (Tylenol) 500 mg PO
☐ Benadryl 25mg PO
☐ Famotidine 20 mg IV
☐ Cetirizine (Zyrtec) 10 mg PO
☐ Methylprednisolone (Solu-Medrol) 125 mg IVP
☐ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE / FREQUENCY	ROUTE
Zoladex	☐ 3.6 mg every 28 days ☐ 3.5 mg followed 28 days later by 10.8 mg (men only) ☐ 10.8 mg every 12 weeks (men only) ☐ Continue indefinitely ☐ Number of doses:_____ **For Endometriosis**: Maximum recommended treatment duration is **6 months**	Sub q Injection

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

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

FAX NUMBERS:
❒ CT: 203.433.0621
❒ FL: 904.877.9270
❒ MA: 413.296.8482
❒ MD: 240.224.8607
❒ ME: 207.407.7272
❒ NC: 919.984.8698
❒ NH: 603.217.5371
❒ NJ: 201.581.4521
❒ NY: 631.250.6020
❒ OH: 937.871.4594
❒ PA: 610.273.5998
❒ SC: 864.973.6279
❒ VA: 703.202.0499