

Darzalex (daratumumab)

Provider Order Form rev. 1/12/2026



PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Patient Full Name: _____ DOB: _____ Phone: _____ Gender: M F Other

Email Address: _____ Address: _____ Weight (lbs/kg): _____ Height (in): _____

NKDA Allergies: _____ Existing prior authorization? Yes, (Send a copy) No (AIC will process)

Patient Status: New to Therapy Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

Patient Preferred Location:

DIAGNOSIS & CLINICAL INFORMATION

ICD 10-Code & Description (Provide full completed code)

C90.00 Multiple myeloma not having achieved remission

C90.01 Multiple myeloma in remission

E85.81 Light chain (AL) amyloidosis

D47.2 Monoclonal gammopathy of undetermined significance (MGUS)

ICD-10 Code: _____

ICD-10 Description: _____

REQUIRED DOCUMENTATION: Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results (CBC, CMP, TB, Hep B panel-depending on medication) , signed prescription order and recent visit notes.

Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

PRESCRIPTION INFORMATION

Nursing: Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

Pre-Medications

Acetaminophen (Tylenol) 500mg 650mg 1000mg PO

Diphenhydramine (Benadryl) 25mg 50mg PO IV

Methylprednisolone (Solu-Medrol) 40mg 125mg IV

Other: _____ Dose: _____ Route: _____

Lab Orders

Required: CBC w/ diff, Hepatitis B Surface Ab, Hepatitis B Surface Ag, Hepatitis B Core Ab, Total, Hep B virus screen communication:

Other: _____

Daratumumab (Darzalex) (Select one):

Route: IVPB

Dose: Infuse 16 mg/kg Other: _____

Frequency: Weekly Every 2 weeks Every 4 weeks Other: _____

Post Treatment Observations: The patient is required to stay for 30 minutes following the first administration.

Refills: zero 6 months 12 months _____ (*Prescription valid for one year, unless otherwise indicated*)

Special Instructions: _____

PROVIDER INFORMATION

Provider Full Name: _____ Provider NPI #: _____ Specialty: _____

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

Contact Name: _____ Phone: _____ Fax: _____ Email: _____

Provider Name (Print)

Provider Signature

Date

Greater Houston Area F: 832.510.7824 P: 832.800.3213

McAllen F: 956.302.8906 P: 832.800.3213 Plano: F: 214.831.9829 P: 972.865.4454

Harlingen F: 956.341.9687 P: 832.800.3213 Laredo F: 956.306.3715 P: 832.800.3213

Other Locations (Oaklawn, Lancaster, etc): F: 469.305.2361 P: 972.865.4454

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E: Referrals@americaninfusioncare.com