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