

Patient Name\* \_\_\_\_\_ Date of Birth\* \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Address \_\_\_\_\_ Patient Phone #\* \_\_\_\_\_

Treatment\* \_\_\_\_\_

Frequency \_\_\_\_\_ Duration\* \_\_\_\_\_ Route\* IV \_\_\_\_ PO \_\_\_\_ Other \_\_\_\_

Labs \_\_\_\_\_ Frequency \_\_\_\_\_

Additional Tests \_\_\_\_\_ Frequency \_\_\_\_\_

\*Per CMS, providers shall use the required ICD-10 diagnosis code **Z00.6**, along with one of the following additional diagnosis codes: **G30.0** (AD with early onset), **G30.1** (AD with late onset), **G30.8** (Other Alzheimer's Disease), **G30.9** (AD, unspecified), **G31.84** (Mild cognitive impairment).

\*\*Additionally, the clinical trial number **MUST** be included **AND** one of these modifiers **MUST** be selected:

**Q0-** Investigational clinical service provided in a clinical research study that is an approved clinical research study  
-OR-

**Q1-** Routine clinical service provided in a clinical research study that is an approved clinical research study.

Procedure Code(s) J0174 \_\_\_\_\_ Diagnosis Code(s)\* \_\_\_\_\_

Modifier(s)\* \_\_\_\_\_ Clinical Trial Number \_\_\_\_\_

Primary Care Provider \_\_\_\_\_

If allergic reaction occurs:

- ☐ Diphenhydramine 25 mg PO/IV PRN itching, SOB, may repeat if symptoms do not improve
- ☐ Solu-Medrol 40 mg IV PRN itching, rash, SOB (or other signs of infusion reaction)
- ☐ Epinephrine (1:1000) 0.3-0.5 mg SQ/IM PRN for anaphylaxis and call
- ☐ O2 2-6 L/minute PRN SOB or chest pain
- ☐ Notify Provider of systolic BP <100, pulse > 100, or temp > 101 degrees F or other concerns

\_\_\_\_\_  
Print Name of Physician\* Physician Signature\* Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**TRISTATE OUTPATIENT SERVICES****PHONE: 509.758.4663****FAX: 509.751.0236**

*\*All sections marked **MUST** be completed or the order form will be returned.*