Fax: 614-929-7199 | Phone: 614-929-3349| Email: info@infuseoneohio.com

INFUSE ONE

Paliperidone orders

Patient Name ______________________________ DOB ____________

Phone Number ___________________________ M ____ F _____

DIAGNOSIS *Please provide ICD-10 code*

☐ ______________ Schizoaffective disorder ☐ _____________ Schizophrenia

PRE-MEDICATIONS (optional)

☐ Acetaminophen 1000mg PO
☐ Diphenhydramine 25mg PO
☐ Cetirizine 10mg PO
☐ ______________________ (other)

☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ _____________________ (other)

Paliperidone ORDERS

DOSAGE & FREQUENCY

Invega Sustenna

Initial dosing

☐ 234mg IM on treatment day 1 followed by 156mg 1 week later

Maintenance

☐ _________mg IM every 4 weeks (max dose 234mg per month)

Invega Trinza

☐ _______mg IM once every 12 weeks

Invega Hafyera

☐ _______mg IM once every 6 months

☐ **Other**: _____________________

NOTES:

ORDERING PROVIDER

Signature __________________________________ Phone__________________Fax__________________

Provider ____ Date _________________