ANTIBIOTIC INFUSION ORDER

Referral Form

DELIVERIT™ Infusion & Specialty
Phone +1.832.939.8137
Fax: +1.832.939.8128

Patient Demographic Information

(Or Attach Face Sheet from Patient Chart)

Patient Name		DOB		Gender	Male ☐ Female ☐	Weight	____lbs ☐ kg ☐
SSN		Phone		Allergies			
Address		City		State		Zip Code	

Patient Insurance Information

(Or Attach Copies of Patient's Insurance Card)

Primary Insurance		Name of the Insured		Relationship	
Member ID#		Group #		Insurance Phone #	
Secondary Rx Carrier		Rx ID #		Rx Group #	

MEDICAL INFORMATION

Allergies:		Diabetic:	☐ yes ☐ No
Primary Diagnosis:		ICD10:	
Patient Status:	☐ New to Therapy ☐ Continuing Therapy	Next Treatment Date	

HOME INFUSION PATIENTS QUESTIONS

Has patient previously received this antibiotic? ☐ Yes ☐ No - If no, can first done be given at home ☐ yes ☐ No

Arrange for first dose outpatient? ☐ Yes ☐ No | Arrange for nursing? ☐ Yes ☐ No

Can we send the following:
☐ Diphenhydramine 25-50mg PO or IV PRN allergic reaction (adult)
☐ Epinephrine 1:1000, 0.3mL IM PRN severe allergic reaction (adult)

Does the patient have an IV line? ☐ Yes ☐ No - If no, arrange for PICC/midline? ☐ Yes ☐ No

Remove PICC/midline at the end of therapy? ☐ Yes ☐ No

THERAPY ORDER

☐ Acyclovir	☐ Cipro	☐ Kimyrsa	☐ Teflaro
☐ Amikacin	☐ Clindamycin	☐ Levaquin	☐ Tigecycline
☐ Amphotericin B	☐ Cubicin	☐ Metronidazole (Flagyl)	☐ Timentin
☐ Ampicillin/Sulbactam (Unasyn)	☐ Dalvance	☐ Merrem	☐ Tobramycin
☐ Avycaz	☐ Doribax	☐ Mycamine	☐ Tygacil
☐ Cefazolin	☐ Fluconazole	☐ Nafcillin	☐ Vancomycin
☐ Cefepime (Maxipime)	☐ Gentamicin	☐ Orbactiv	☐ Vibativ
☐ Ceftazidime (Fortaz)	☐ Imipenem/Cilastatin (Primaxin)	☐ Oxacillin	☐ Xerava
☐ Ceftriaxone (Rocephin)	☐ Invanz	☐ Piperacillin/ ☐ Tazobactam (Zosyn)	☐ Do not substitute
☐ Other:			

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THERAPY ORDER

Dose:	_____	mg	_____	**grams**	_____	**mg/kg**	_____

Frequency:

☐ Daily ☐ Every 8 hours ☐ Continous over 24 hours
☐ Every 12 hours ☐ One does ☐ Every __ Hours ☐ Other

Flush Orders:

☐ NS 1-20mL pre/post infusion PRN ☐ D5W 1-20mL pre/post infusion PRN
☐ Heparin 10U/mL per protocol as indicated ☐ Heparin 100U/mL per protocol as indicated

Lab Orders: **Frequency:** ☐ Weekly ☐ Other _____

Other Orders: **Required labs to be drawn by:** ☐ DeliverIt Pharmacy ☐ Prescriber

Prescriber Insurance Information

Prescriber Name		**NPI#**		**Office #**		**Fax #**	
Address		**City**		**State**		**Zip Code**	

☐ I Authorize DeliverIt specialty pharmacy to initiate Prior Authorizations on my behalf.

☐ DAW (Dispense as written).

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. No stamped signatures will be accepted. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through DeliverIt Group, this prescription shall be forwarded to an eligible pharmacy.

Date

Prescriber's Signature

X _____

Please fax all information to (877)993-3548 or call (832)939-8128 for assistance