INFUSION THERAPY REFERRAL FORM

Phone: 877-778-0318 Fax: 877-778-0399

Ship to: ☐ Patient ☐ Physician / Clinic Date Shipment Needed: _____ **Rx:** ☐ New ☐ Refill _____

PATIENT INFORMATION

Patient's Full Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____

Alternate Phone: _____

Patient's Social Security Number: _____

Patient's Date of Birth: _____

Allergies: _____

Patient's Gender (Male or Female): _____

Diagnosis: _____ **ICD9 Code:** _____

Patient Weight: _____ Height: _____

Primary Insurance: _____

ID #: _____ Phone: _____

Secondary Insurance: _____

ID #: _____ Phone: _____

PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

IV MEDICATION

- ☐ Ancef (Cefazolin)
- ☐ Cubicin (Daptomycin)
- ☐ Invanz (Ertapenem)
- ☐ Levaquin (Levofloxacin)
- ☐ Maxipime (Cefepime)
- ☐ Primaxin (Imipenem)
- ☐ Rocephin (Ceftriaxone)
- ☐ Solu-Medrol (Methylprednisolone)
- ☐ Unasyn (Ampicillin-sulbactam)
- ☐ Vancomycin (Vancocin)
- ☐ Zosyn (Piperacillin)
- ☐ IVIG (Immune Globulin)
- ☐ TPN (Parental Nutrition)
- ☐ Other:

DIRECTIONS (Frequency of Administration)

NURSING

☐ AP NURSING _____

☐ AGENCY _____

1st DOSE

☐

LINE ACCESS

☐ PICC ☐ PERIPHERAL _____

☐ OTHER _____

ADDITIONAL IV THERAPY / SERVICES REQUESTED

PICC LINE CARE	☐Weekly	☐Monthly	Orders:
LABS	☐Weekly	☐Monthly	Orders:
WOUND CARE	☐Weekly	☐Monthly	Orders:
PHARMACOKINETIC DOSING	☐Weekly	☐Monthly	Orders:
SPECIAL IV INSTRUCTIONS			

PRESCRIBER INFORMATION

Physician's Name (Please Print): _____ NPI#: _____

Address: _____ License#: _____

City, State, Zip: _____ DEA#: _____

Phone: _____ Fax: _____ Contact Name: _____

Physician's Signature: _____ Date: _____

I authorize AmeriPharma Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.