Antibiotic Referral Form

Fax Completed Form To: **Phone:**

amerita specialty infusion services — Ivy Specialty Infusion, an amerita company

PATIENT INFORMATION

Please include ALL clinical/office notes, lab results, H&P related to therapy and list of current medications/allergies.

Patient Name:	Date of Birth:	Phone:
Patient Weight:	Patient Allergies:	

INSURANCE INFORMATION *Please attach FRONT and BACK copy of all insurance cards (Prescription and Medical)*

Diagnosis:	ICD -10

PRESCRIPTION INFORMATION *All necessary supplies will be provided as needed*

Start Date of Therapy:

Medication	**Dose/Route/Directions**	**Duration**	**Quantity**
☐ Ceftriaxone	_____ gm IV every ___ hours	for ___ days	# QS
☐ Daptomycin	_____ mg/kg IV every ___ hours	for ___ days	# QS
☐ Dalbavancin	_____ mg IV every ___ hours	for ___ days	# QS
☐ Ertapenem	_____ gm IV every ___ hours	for ___ days	# QS
☐ Meropenem	_____ gm IV every ___ hours	for ___ days	# QS
☐ Nafcillin	_____ gm IV every ___ hours	for ___ days	# QS
☐ Check if Nafcillin is a continuous infusion			
☐ Oritavancin	_____ mg IV every ___ hours	for ___ days	# QS
☐ Piperacillin/Tazobactam	_____ gm IV every ___ hours	for ___ days	# QS
☐ Telavancin	_____ mg/kg IV every ___ hours	for ___ days	# QS
☐ Vancomycin	_____ mg IV every ___ hours	for ___ days	# QS

☐ Check if pharmacy is to clinically manage Vancomycin dosing

Other IV antibiotic medication:_____

IV Access type: ☐ Peripheral ☐ PICC line ☐ Port ☐ CVAD (Central Venous Access Device) ☐ Admit to Home Health Agency _____

Anaphylaxis Orders: (Nursing to call MD if patient has anaphylactic reaction)

☐ Epinephrine ☐ 1:1000 0.3mL IM as needed for anaphylaxis, and Diphenhydramine ☐ 25-50 mg IM as needed for anaphylaxis

☐ Sodium Chloride 0.9% ☐ mL IV to provide fluid as needed

☐ Other: _____

IV access flushing and line care orders:

☐ Heparin ☐10 units/ml ☐100 units/ml Flush line with 3-5 ml after last saline flush and into unused IV line if needed

☐ Sodium chloride 0.9% Flush line with 5-10 ml before and after each dose of medication infused and into unused IV line if needed

☐ Other: _____

☐ IV site dressing change every ___ days

LAB TESTS:

☐ CBC with DIFF ☐ CMP ☐ BMP ☐ ESR ☐ Other labs _____ ☐ No Labs

Physician Information

Physician Name:	Lic.#:	DEA #:	
Practice Name:	NPI #:	Specialty:	
Address:	City:	State:	Zip:
Nurse Contact:	Phone:	Fax:	
Physician Signature:		Date:	

By signing this form and utilizing our services, you are authorizing Amerita to assist with prior authorization requests acting as your pharmacy provider in dealing with medical and prescription insurance companies.

AME IVY_ANTIBIOTIC REFER 6.25

ameritaiv.com

THIS FORM IS NOT VALID FOR USE IN THE STATE OF ARIZONA.

URAC ACCREDITED Specialty Pharmacy 08/01/2020 — ACHC ACCREDITED — PCAB ACCREDITED Compounding Pharmacy