Antibiotic Referral Form

Fax Completed Form To: **Phone:**

Amerita
YOUR INFUSION ADVOCATE

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**
☐ Ampicillin	_____ gm IV every ___ hours	for ___ days	# QS
☐ Ampicillin-sulbactam	_____ gm IV every ___ hours	for ___ days	# QS
☐ Cefazolin	_____ gm IV every ___ hours	for ___ days	# QS
☐ Cefepime	_____ gm IV every ___ hours	for ___ days	# QS
☐ Ceftazidime	_____ gm IV every ___ hours	for ___ days	# QS
☐ Ceftriaxone	_____ gm IV every ___ hours	for ___ days	# QS
☐ Daptomycin	_____ mg/kg IV every ___ hours	for ___ days	# QS
☐ Ertapenem	_____ gm IV every ___ hours	for ___ days	# QS
☐ Gentamicin	_____ mg/kg IV every ___ hours	for ___ days	# QS
☐ Imipenem cilastatin	_____ gm IV every ___ hours	for ___ days	# QS
☐ Meropenem	_____ gm IV every ___ hours	for ___ days	# QS
☐ Nafcillin	_____ gm IV every ___ hours	for ___ days	# QS
☐ Penicillin G potassium	_____ IV units / Day	for ___ days	# QS
☐ Piperacillin-tazobactam	_____ gm IV every ___ hours	for ___ days	# QS
☐ Tobramycin	_____ mg/kg IV every ___ hours	for ___ days	# QS
☐ Vancomycin	_____ gm IV every ___ hours	for ___ days	# QS

Other IV antibiotic medication:_____

Nursing Orders: Nurse to provide assessment, lab draws, medication administration and vascular access device insertion and/or management per physician order

Supply Orders: All supplies for vascular access line care, drug administration kits, pump and IV pole will be provided as necessary

Flush Orders: ☒ 0.9%NaCl 10ml flush pre and post infusion and as needed

Heparin ☐ 10units/ml OR ☐ 100units/ml 5ml flush if indicated to maintain line ☐ Other_____

Lab Orders: ☐ CBC w diff, CMP, CRP ☐ Trough ☐ CPK ☐ ESR ☐ Other_____Frequency_____

Anaphylaxis Order: ☐ **(Nursing to call MD if patient has anaphylactic reaction)**

Diphenhydramine 50mg IVP x1, Epinephrine 0.3mg IM x1, may be repeated after 15 minutes as needed for severe reactions; 0.9% NaCl IV 500mL

Solu-Medrol ☐ 125mg IV as needed Solu-Cortef ☐ 100mg IV as needed ☐ Other_____

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

☐ 2 mg Cathflo as needed - allow to dwell in catheter for up to 2 hours; second dose if remains occluded

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_Antibiotic Referral Form 7.31

ameritaiv.com

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

urac ACCREDITED Specialty Pharmacy 09/01/2025 | ACHC ACCREDITED | PCAB ACCREDITED Compounding Pharmacy