



## PRESCRIPTION and INFUSION ORDER



**Order Date:\***

**Preferred Location:**

### PATIENT INFORMATION

**Patient Name:\***

First Name

Middle Initial

Last Name

Suffix

**Date of Birth:\***

**Preferred Language:**

**Phone:\***

**Known As:**

Nickname

**Address:\***

Address Line 1

Address Line 2

City

State

ZIP Code

Country

### PROVIDER INFORMATION

**Practice Name:**

**Prescriber Name:\***

**NPI Number:\***

**Contact Name:\***

**Contact Phone:\***

**Contact Email:\***

**Fax Number:**

**Address:\***

Address Line 1

Address Line 2

City

State

ZIP Code

Country

**PATIENT'S INSURANCE**

If you have the following information, it will speed the authorization process. If not, we will obtain it from the patient.

**Primary Insurance:\*****Member Number:\*****Secondary Insurance:****Member Number:****DIAGNOSIS****Primary ICD-10 Code/Description:\*****Secondary ICD-10 Code:****Description:****PRESCRIPTION****Patient Weight:\*****Pre-Medication:**

- ☐ Methylprednisolone 125 mg IV
- ☐ Diphenhydramine 25 mg IV
- ☐ Diphenhydramine 50 mg IV
- ☐ Acetaminophen 500 mg PO

**Pre-Medication:**

- ☐ Methylprednisolone 100 mg IV
- ☐ Diphenhydramine 25 mg PO
- ☐ Diphenhydramine 50 mg PO
- ☐ Other:

**Induction Dosing:**

- ☐ 10 mg/kg IV at week 0, 2 and 4
- ☐ 500 mg IV at week 0, 2 and 4
- ☐ 750 mg IV at week 0, 2 and 4
- ☐ 1000 mg IV at week 0, 2 and 4

**Additional Optional Loading Dose:**

- ☐ 500 mg IV at week 8
- ☐ 750 mg IV at week 8
- ☐ 1000 mg IV at week 8

**Maintenance Dosing:**

- ☐ 500 mg IV every 4 weeks
- ☐ 750 mg IV every 4 weeks
- ☐ 1000 mg IV every 4 weeks

Refills

**Alternate Dosing:**

Specify strength, route, frequency

Refills

**LAB ORDERS**

Coastal Infusion will draw labs on request. Please enter those orders below.

**TB Test:**

Timing/Frequency

**Hep B Test:**

Test Name, Timing, Frequency

**Lab:**

Test Name, Timing, Frequency

**AUTHORIZATION**

My signature below certifies that the above-named individual is my patient and the therapy ordered is medically necessary. I understand that Coastal Infusion will follow industry best practices in the administration of this treatment. If I have specific additional instructions, I have entered them below.

**Additional Instructions:****Signature:\***

Signature must match the Prescriber Name

**ATTACHMENTS****Required Attachments:**

The following specific documents are required for this drug. Please attach the following forms:

- ☐ PT Demographics (from Provider's EMR)
- ☐ Most recent clinical note
- ☐ TB Test
- ☐ Hep B Test

**Optional Attachments:**

Coastal Infusion can secure the following from the patient; however if this information is readily available, including it may speed the authorization process. Please check which forms are attached:

- ☐ Patient's Primary Insurance Card – Front
- ☐ Patient's Primary Insurance Card – Back
- ☐ Patient's Secondary Insurance Card – Front
- ☐ Patient's Secondary Insurance Card – Front