

**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****Initial Dose/Course:**

- ☐ 100 mg IV every 3 months
- ☐ 300 mg IV every 3 months
- ☐ Other

Specify strength, route, frequency

Refills

LAB ORDERS

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

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

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
- ☐ Additional Information