



PRESCRIPTION and INFUSION ORDER



All Purpose Order Form

(May be used for any drug when a specific form is not available)

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's Weight:***☐ lbs☐ kgs**Patient's Height:**☐ inches☐ cm**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:

PRESCRIPTION**Drug:*****Dosage:*****Route:*****Frequency:*****Refills****Drug:****Dosage:****Route:****Frequency:****Refills**

LAB ORDERS

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

CVC:

Timing/Frequency

JCV:

Timing/Frequency

BMP:

Timing/Frequency

CMP:

Timing/Frequency

Hep-B Panel:

Timing/Frequency

TB Test:

Timing/Frequency

Infliximab Levels:

Timing/Frequency

IGG Levels:

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
☐ CBC Panel
☐ JCV Test Results | ☐ Hep-B Test Results
☐ Dexascan
☐ MRI
☐ Additional Lab Document |
|---|--|

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

Confidential when completed. Do not send via unsecured email. Fax completed forms to (954) 361-8699.