



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