



## PRESCRIPTION and INFUSION ORDER



Order Date:\*

Preferred Location:

### PATIENT INFORMATION

Patient Name:\*

Suffix

First Name

Middle Initial

Last Name

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**

- 150 mg SC at week 0 and week 4
- 600 mg IV at week 0, week 4, and week 8
- 1200 mg IV at week 0, week 4, and week 8

**Induction Dosing**

- 150 mg SC every 12 weeks after induction dosing
- 180 mg SC at week 12 and every 8 weeks thereafter
- 360 mg SC at week 12 and every 8 weeks thereafter

Refills

**Alternate Dosing**

Specify strength, route, frequency

Refills

**LAB ORDERS**

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

**Hep B Panel:**

Timing/Frequency

**TB Test:**

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
- Hep B Panel
- TB 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