pharmacy SPECIALISTS

P: 877.217.3619 • F: 877.220.6086
pharmacy-specialists.com

Antibiotic Order Form

REQUIRED: Demographics & Most recent H&P, Clinical Notes, and Medication List

PATIENT INFORMATION

Patient Name ______ Date of Birth ______ Gender ☐ Male ☐ Female

Address ______

Home Phone ______ Work Phone ______ Cell Phone ______

INSURANCE INFORMATION: Please fax a copy of the insurance card(s) with this form (front and back)

MEDICAL INFORMATION

Weight (kg) ______ Height ______ Allergies ______

Diagnosis ______ ICD-10 ______

Patient Status ☐ New to Therapy ☐ Continuing Therapy Next Treatment Date ______

Line Access ☐ Port ☐ PICC Other: ______ Lumens ☐ 1 ☐ 2 ☐ 3

MEDICATION ORDERS

MEDICATION	DOSE	ROUTE	FREQUENCY	DURATION OF THERAPY

Has patient previously received this antibiotic? ☐ Y ☐ N If no, can first dose be given in the home ☐ Y ☐ N

ADDITIONAL ORDERS

Flush Orders:
- Sodium Chloride 0.9% Flush 5-10ml pre/post infusion PRN.
- Heparin 10u/ml or Heparin 100u/ml per protocol as indicated PRN.

PICC line to be pulled at the end of therapy by:
☐ Home Health ☐ MD Office / Clinic ☐ Other ______

Cathflo 2mg:
- Administer PRN for occluded Catheter

Anaphylactic Reaction Orders:
- Diphenhydramine 25mg-50mg IM/IV PRN allergic reaction (adult)
- Epinephrine 1:1000 (mg/ml) PRN severe allergic reaction (based on patient weight)
  - o >30kg (>66lbs): Epinephrine 0.3mg IM or subQ; may repeat in 5-15 minutes x 1
  - o 15-30kg (33-66lbs): Epinephrine 0.15 IM or subQ; may repeat in 5-15 minutes x 1

LAB ORDERS AND FREQUENCY

☐ **CBC, CMP, ESR, CRP weekly** ☐ **Daptomycin: CPK weekly** ☐ **Vancomycin Trough: 30min prior to dose weekly**

Other ______ **Frequency:** ______ **Other** ______ **Frequency:** ______

PROVIDER INFORMATION

By signing this form and utilizing our services, the prescriber is authorizing *Pharmacy Specialists* and its employees to serve as their prior authorization and designated agent in dealing with medical and prescription insurance companies. The prescriber certifies that the use of the indicated treatment is medically necessary, and the prescriber will supervise the patient's treatment.

Prescriber Name ______ Signature ______ Date ______

Prescriber NPI ______ Phone ______ Fax ______ Contact Person ______

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Patient Name	

REQURIED DOCUMENTATION FOR REFERRAL PROCESSING AND INSURANCE APPROVAL

- ☐ Include signed and completed order
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's medication list
- ☐ Supporting clinical notes (H&P) to support primary diagnosis
- ☐ Baseline labs attached
- ☐ Culture results attached (if applicable)
- ☐ PICC/Central line placement confirmation (if applicable)
- ☐ Other medical necessity: ______________________________

REFERRAL AND INSURANCE APPROVAL PROCESS: Please submit a completed order form and all required documentation. *Pharmacy Specialists* will complete insurance verification and submit all required documentation to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. Financial responsibility will be reviewed with the patient. Any available co-pay assistance programs will be discussed with the patient as needed. Thank you for the referral.

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