AYSA
THERAPEUTICS INFUSION

INFUSION ORDER FORM

P: 470.395.6076 | F: 470.745.0716

PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: _____ DOB: _____ Phone: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)

MEDICAL INFORMATION

Patient Weight: _____ lbs. Allergies: _____

Diagnosis Date: _____ ICD-10: _____

☐ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: _____

INFUSION ORDERS

DIAGNOSIS	INFUSION ORDERS
☐ Dehydration (ICD-10 _____) ☐ Gastroenteritis (ICD-10 _____) ☐ Diverticulitis (ICD-10 _____)	☐ 1 Liter/ ☐ 2 Liters D5 .45% NS IV x 1 day ☐ 1 Liter/ ☐ 2 Liters NS IV x 1 day ☐ **Cipro** 400mg IV daily x 1 day ☐ **Flagyl** 500mg IV daily x 5 days ☐ **Invanz** 1gm IV daily x 1 day ☐ **Rocephin** 1gm IV daily x 7 days
☐ Iron Deficiency Anemia (ICD-10 _____) ☐ Iron Deficiency Anemia with CKD not on dialysis (ICD-10 _____)	☐ **Venofer** 200mg IV q 3 weeks x 5 doses ☐ **Venofer** 100mg IV q week x 7 weeks then every other week x 7 weeks (10 doses total) ☐ **Venofer** 200mg IV - Administer 5 doses over a 14 day period ☐ **Injectafer** 15mg/kg IV - Give 2 doses at least 7 days apart not to exceed 1500mg *-if patient weighing less than 50kg (11lbs.)* ☐ **Injectafer** 750mg IV -Give 2 doses at least 7 days apart not to exceed 1500mg *-if patient weighing 50kg (110lbs.) or greater*
☐ Nausea/Vomiting (ICD-10 _____)	☐ **Zofran** 4mg slow IVP ☐ **Reglan** 10mg IV/100mL NS over 20 minutes ☐ **Zofran** 8mg slow IVP
☐ Pneumonia (ICD-10 _____)	☐ **Zithromax** 500mg IV daily x 3 days ☐ Invanz 1gm IV daily x 7 days
☐ Chronic Sinusitis (ICD-10 _____)	☐ **Rocephin** 2gms IV daily x 14 days ☐ Invanz 1gm daily x 14 days
☐ Chronic Bronchitis (ICD-10 _____)	☐ **Zithromax** 500mg IV daily x 3 days ☐ **Solu-Medro**l 125mg IVP x 1 day, then 62.5 mg IVP x 2 days
☐ Pyelonephritis (ICD-10_____) ☐ Complicated UTI (ICD-10 _____)	☐ **Rocephin** 2gms IV daily x 7 days ☐ **Invanz** 1gm IV daily x 7 days
☐ Cellulitis/MSSA (ICD-10 _____) ☐ Location: _____	☐ **Rocephin** 1gm IV daily x 7 days
☐ MRSA (ICD-10 _____) ☐ Location: _____	☐ **Cubicin** 4mg/kg IV daily x 6 weeks ☐ **Cubicin** 6mg/kg IV daily x 7 days ***Baseline CPK required for Cubicin***
☐ Osteomyelitis (ICD-10 _____) ☐ Location: _____	☐ **Rocephin** 2gms IV daily x 6 weeks ☐ **Cubicin** 6mg/kg IV daily x 7 days ☐ **Cubicin** 4mg/kg IV daily x 6 weeks ***Baseline CPK required for Cubicin***
☐ Multiple Sclerosis Exacerbation (ICD-10_____)	☐ **Solu-Medrol** 1gm IV daily for ☐ 3 days ☐ 5 days ☐ **Zofran** 4-8mg slow IVP ☐ **Reglan** 10mg IV/100mL NS over 20min
☐ Migraines (ICD-10_____)	☐ **Depacon** 500mg IV/250mLs NS ☐ **Magnesium Sulfate** 1gm IV/250mL NS ☐ **DHE** 45 1mg IV/100mL NS (must premed for nausea) ☐ **Solu-Medrol** 125mg IV ☐ **Zofran** 4mg IVP may Repeat x 1 ☐ **Toradol** 30mg IVP

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing *At Your Service Anesthesia, Inc.*, and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Physician Name: _____ Date: _____

Phone: _____ Fax: _____ Contact Person: _____