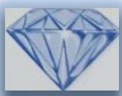

AYSA
THERAPEUTICS INFUSION

OB/GYN 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: ____________________

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

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

Lab Orders: ____________________

INFUSION ORDERS

DIAGNOSIS	INFUSION ORDERS	REFILLS
☐ Hyperemesis: ________	☐ 1 Liter/ ☐ 2 Liters D5 .45% NS IV x 1 day ☐ 1 Liter/ ☐ 2 Liters NS IV x 1 day ☐ 1 Liter/ ☐ 2 Liters Ringers Lactate IV x 1 day ☐ 1 Liter/ ☐ 2 Liters D5/Ringers Lactate x 1 day ☐ Zofran 4mg IV ☐ Zofran 8mg IV	☐ ______
Primary ICD-10 ☐ Iron Deficiency Anemia: ______ ☐ Iron Deficiency Anemia with CKD not on dialysis: ______ ☐ Other medical necessity: ______ **Required Recent Labs: HGB, HCT, TIBC, Ferritin**	**Last Iron dose** (if applicable) ______ **Secondary ICD-10** ☐ Adverse Effect of other drug ______ *(Oral iron intolerance or not adequate)* ☐ Other medical necessity: ______ ☐ **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 ☐ **Venofer** 200mg IV weekly x 5 weeks ☐ **Injectafer** 15mg/kg IV - Give 2 doses at least 7 days apart not to exceed 1500mg *if patient weiging less than 50kg (110lbs.)* ☐ **Injectafer** 750mg IV - Give 2 doses at least 7 days apart not to exceed 1500mg *if patient weighing 50kg (110lbs.) or greater*	☐ ______
☐ Pyelonephritis: ______ ☐ Complicated UTI: ______ **Required Labs: CBC, BMP**	☐ Rocephin 1gm IV daily x 7 days ☐ Rocephin 2gms IV daily x 7 days ☐ Invanz 1gm IV daily x 7 days	______
☐ Migraines: ______ **Required Labs: LFTs if ordering Depacon treatment**	☐ Zofran 4mg IV ☐ Zofran 8mg IV ☐ Reglan 10mg IV ☐ Magnesium Sulfate 1gm IV ☐ Depacon 500mg IV ☐ DHE 45 1mg IV	☐ ______

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: ____________________

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