OB/GYN INFUSION ORDER FORM
P: 240.200.4464 F: 240.892.3005

PATIENT INFORMATION: Fax completed form, insurance information, and clinical documentation to 240.892.3005

Patient Name: _____ DOB: _____ Phone: _____

MEDICAL INFORMATION

Patient Weight: _____ lbs./kg. (required) Allergies: _____

THERAPY ORDER

Diagnosis	Infusion Orders	
☐ Mild Hyperemesis ☐ Hyperemesis w/ metabolic disturbance ☐ Other: _____ **ICD-10: _____**	☐ 1 Liter ☐ 2 Liters D5 0.45 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 D5/Ringers Lactate x 1 day	☐ **Zofran** 4mg IVP x1 ☐ **Zofran** 8mg IVP x 1 ☐ May repeat regimen x _____ days
☐ Iron Deficiency Anemia ☐ Other medical necessity: _____ **ICD- 10: _____**	****If the patient has Aetna, Cigna, Humana, or UHC, the patient must try and fail Venofer first**** ☐ **Venofer** 200mg IV – Administer 5 doses over a 14-day period ☐ **Venofer** 200 mg IV weekly x 5 doses ☐ **Injectafer** 15mg/kg IV – Give 2 doses at least 7 days apart not to exceed 1500mg (weight <50kg) ☐ **Injectafer** 750mg IV – Give 2 doses at least 7 days apart not to exceed 1500mg (weight >50kg) ☐ **Monoferric** 20mg/kg IV x 1 dose (weight <50kg) ☐ **Monoferric** 1000mg IV x 1 dose (weight >50kg)	
☐ Pyelonephritis ☐ Complicated UTI ☐ Other: _____ **ICD-10: _____**	☐ **Rocephin** 1gm IV daily x 7 days ☐ **Rocephin** 2gms IV daily x 7 days ☐ **Ivanz** 1gm IV daily x 7 days ☐ Other: _____	
☐ Migraines ☐ Other: _____ **ICD-10: _____**	☐ **Zofran** 4mg IVP x 1 ☐ **Zofran** 8mg IVP x 1 ☐ **Reglan** 10mg IV x 1 ☐ May repeat regimen x _____ days	****NON-OB PATIENTS ONLY**** ☐ **Magnesium Sulfate** 1 gm IV x 1 ☐ **Depacon** 500mg IV x 1 ☐ **DHE-45** 1mg IV x 1
☐ Other: _____ **ICD-10: _____**	☐ Other: _____	

Please provide patient's demographic information, insurance information, medication list, and clinical notes. Active Infusions will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and assist them in enrolling in any available co-pay assistance programs as needed/applicable. Thank you for the referral.

PROVIDER INFORMATION

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

IMPORTANT NOTICE: This fax is intended to be delivered only to the named address and contains material that is confidential, privileged property, or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately and destroy all copies if you have received this document in error.