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: _____

ACTIVE INFUSIONS | Patient Demographics Request

Dear Provider / Office Staff,

We have received a referral for the above patient and will be reaching out to begin the scheduling process. To ensure we are able to make contact in a timely manner, we kindly ask that your office confirm or complete the patient demographic information below. This helps us verify accurate contact details prior to outreach and avoid any delays in care.

Please complete and return via fax to 240-892-3005 or email kendrick@activeinfusions.com. Thank you!

PATIENT CONTACT INFORMATION

Please confirm or provide the most current contact information you have on file for this patient.

Patient Name

Last, First MI

Date of Birth

MM / DD / YYYY

Primary Phone Number

Best phone number

Alternate Phone Number

Alternate number

Email Address

Patient email address

Patient's Preferred Method of Contact:

☐ Phone Call ☐ Text Message ☐ Email ☐ No Preference

EMERGENCY CONTACT

Required for ALL patients receiving therapy for Alzheimer's Disease

Emergency Contact Name

Full name

Relationship to Patient

e.g. Spouse, Child, Friend

Emergency Contact Phone

Phone number

Emergency Contact Email

Email (if available)

PRIMARY INSURANCE: SUBSCRIBER INFORMATION

Please confirm the subscriber / policy holder information for the patient's primary insurance.

Is the patient the Subscriber / Policy Holder? ☐ Yes ☐ No

Subscriber / Policy Holder Name

Full name

Relationship to Patient

e.g. Self, Spouse, Parent

Subscriber Date of Birth

MM / DD / YYYY

Subscriber Member ID

Member ID

Insurance Company

Insurance name

Group Number

Group number

COPAY ASSISTANCE PROGRAM

If the patient is enrolled in a manufacturer copay or patient assistance program, please provide details if available.

Program Name

Program name

Program ID Number

ID number on card

NOTES / ADDITIONAL INFORMATION