promptcare™
Specialty Pharmacy & Infusion Services
An AOM Infusion Company

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General Infusion Therapy Order Form

Patient Name: _____ DOB: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

1. For new patients, please submit with form:

☒ Copy of insurance card ☒ History & physical
☒ Patient demographics ☒ Pertinent labs and test results based on therapy type and diagnosis

2. Patient Information

☐Male ☐Female Height: _____ in/cm Weight: _____ lbs/kg ☐NKDA Allergies: _____
Is this the first dose? Yes No, date of last infusion: _____ Next due: _____ Line type: ☐PIV ☐PICC ☐Port ☐Other

3. Diagnosis and Clinical Information

ICD-10 (required): _____ Primary diagnosis: _____ Other information: _____

4. Prescription Information

Medication	Medication: _____ Strength/formulation: _____
Dose / Frequency	Dose: _____ Frequency: _____
Directions	Route of administration: Intravenous Subcutaneous Other: _____ ☒ Prepare and infuse medication per manufacturer guidelines, as tolerated and per PromptCare Policy & Procedure ☐ Other: _____
Quantity / Refills	☒ Dispense 1 month supply / QS on all selected medications / Refill x 12 months ☐ Other: _____ Dispense all medical supplies necessary for infusion

5. Additional Orders

Premedications: Give 30 min prior to infusions (*Note: if nothing is checked, no premedications will be given*)

Adults (or patients weighing >40kg):

☐ Diphenhydramine 25-50mg PO. Patient may decline.
☐ Acetaminophen 325-650mg PO. Patient may decline.
☐ Methylprednisolone 40mg (OR _____mg) slow IV push (or equivalent corticosteroid, substitution if needed by pharmacy)

Pediatrics (weighing <40 kg): *(may adjust with weight changes)*

☐ Diphenhydramine 1mg/kg PO
☐ Acetaminophen 15mg/kg PO
☐ Methylprednisolone 1 mg/kg (OR _____mg) slow IV push (or an equivalent corticosteroid, substitution if needed by pharmacy)

☐ Other: _____

For infusions to be administered by RN:

☒ RN to start peripheral IV or use existing CVC. RN to administer catheter flushing per PromptCare Policy and Procedure
☒ RN to instruct patient to hydrate pre/post infusion and educate on taking OTC diphenhydramine and/or acetaminophen per manufacturer dosing recommendations as needed to prevent/treat post-infusion headache.
☒ RN to monitor patient for at least 30 min post infusion (or per protocol specific to therapy) and educate on possible side effects, allergic reactions, and when to contact physician

☐ Other: _____

6. Adverse Reaction Orders

☒ Standard anaphylaxis kit to be dispensed and dosed per protocol if indicated:
Epinephrine IM/SQ (1 mg/mL vial), diphenhydramine IV/IM (50 mg/mL vial), and NS IV. Additional orders: _____
Note: for independent patients requiring an EpiPen in home due to risk of anaphylaxis, prescriber to send EpiPen prescription to retail pharmacy

7. Prescriber Information

Prescriber Name: _____ Office Contact: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
License No.: _____ DEA NO.: _____ NPI: _____

_____ _____ _____ _____
Physician Signature (Substitution Permitted) Date **Physician Signature (Dispense as Written)** Date

By signing I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment. PromptCare has my permission to contact the patient's health plan to obtain any authorizations necessary to enable it to receive payment for services.

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