Anti-Infective Enrollment Form

Fax Referral To: 877-828-3941
Phone: 877-828-3940
referrals@infucarerx.com
www.infucarerx.health

Please cut along the dotted lines before submitting to a pharmacy.

Date Required: ______________ Ship To: Patient MD Office Other: ______________

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: ______	Prescriber Name: ______
Address: ______	Address: ______
City, State, Zip: ______	City, State, Zip: ______
Home Phone: ______	Phone: ______
Cell Phone: ______	Fax: ______
Date of Birth: ______ Gender: ______	DEA #: ______ NPI #: ______
Emergency Contact: ______ Phone: ______	Contact Person: ______

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: ______ ID: ______ Group: ______
Secondary Insurance: ______ ID: ______ Group: ______
Prescription Card: ______ ID: ______ BIN: ______ PCN: ______

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

PATIENT DIAGNOSIS/CLINICAL INFORMATION

- L08.9 Skin Infection
- M86.9 Osteomyelitis
- L03.90 Cellulitis
- N39.0 UTI
- A49.9 Bacterial infection unspecified
- E84.9 Cystic Fibrosis
- J06.9 Respiratory Infection
- Other: ______

Route: PICC Line Midline Tunnelled PICC Port Peripheral
Weight: ______ kg lbs Height: ______ cm in %BSA: ______
Allergies: ______ NKDA
Lab Orders: CBC w/ diff: ______ CMP: ______ ESR: ______
CRP: ______ CPK: ______ Misc: ______
VANCOMYCIN trough to be drawn ______

PRESCRIPTION INFORMATION

Medication:	Dose/Strength:	Directions:	Duration of Therapy:	End of Therapy:
CEFAZOLIN (Ancef®)	1gm 2gm 6gm	Q______ Continuous ______		
CEFEPIME (Maxipime)	______gm	Q______		
CEFTRIAXONE (Rocephin®)	1gm 2gm	Q______		
CLINDAMYCIN	300mg	Q______		
DAPTOMYCIN (Cubicin®)	______ mg per kg daily			
ERTAPENEM (Invanz®)	500mg 1g	Q24		
MEROPENEM (Merrem®)	______mg ______g	Q______		
UNASYN	1.5gm 3gm	Q______		
VANCOMYCN	______mg ______g	Q______		
ZOSYN	2.25g 3.375g 4.5g 13.5g	Q______ Continuous ______		
Other: ______				
Other: ______				

PREMEDICATION ORDERS/OTHER MEDICATIONS

Flush Protocol
- NaCl 0.9% 5mL
- NaCl 0.9% 10mL

Heparin 10 units per mL
Heparin 100 units per mL

250mL 0.9% NaCl for hydration
Other: ______

Premedications & Other Medications
- Infusion supplies as per protocol
- Anaphylaxis Kit orders as per protocol

Acetaminophen ______ mg PO prior to infusion
Diphenhydramine ______ mg PO

By signing this form and using this pharmacy's services, you are authorizing this pharmacy to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.

Prescriber Signature: ______________ **Date:** ______

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