

MRN: _____

DOB: _____

Standard Plan of Treatment for Generic Orders

NOTE: We may require a detailed Letter of Medical Necessity or clinical supporting documentation (depending on diagnosis), to be able to verify eligibility and payment for this treatment through Medicare and/or other insurance plans.

1. Patient Name: _____ Height (inches): _____ Weight (lbs): _____

2. Allergies: _____

3. Diagnosis: Primary ICD-10 Code: _____ Diagnosis description: _____

Secondary ICD-10 Code: _____ Diagnosis description: _____

4. Pre-medications: Administered 30 minutes prior to infusion as selected:

Acetaminophen:

- 1000 mg PO
- 650 mg PO
- 500 mg PO
- 325 mg PO

Diphenhydramine: 25 mg PO, 50 mg PO, 25 mg IVP, 50 mg IVP or
Fexofenadine 60mg or 180 mg, Cetirizine 10 mg, Loratadine 10 mg
Methylprednisolone 40 mg IVP 125 mg IVP or other _____mg IVP
Famotidine: 20 mg PO, 40 mg PO, 20 mg IVP, 40 mg IVP

Pre-medicate with other: _____

4. Drug: _____

5. Dose: _____ to infuse over _____ minute(s), _____ hour(s)

6. Administered via (circle one):

Intravenously – Subcutaneously (SQ) – Intramuscular (IM) – IVP

7. Frequency: _____

Post infusion monitoring as per protocol or as suggested in product information of _____ minutes

Special orders: _____

If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES

8. Physician's Signature: _____ / _____ Date: _____

No Stamp Signatures

(Dispense as written)

(Substitution permitted)

Printed Physician's Name with Credentials: _____ NPI: _____

MRN: _____

DOB: _____

Guidelines for Prescribing

(Required documentation with all initial referrals)

Patient Name: _____

Referral Date: _____

- ___ Include signed and completed **Plan of Treatment**.

- ___ Include patient demographic information and insurance information. (Copy of insurance cards if available)

- ___ **Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy. Include any lab results and/or tests to support diagnosis.**

- ___ Other as requested: _____



Checklist for referrals to AccuRX Infusion Center:

Fax referral to 1-866-990-3192

- Patient demographics – address, phone number, SS#, etc.
- Insurance Information – copy of the card(s) if possible
- Plan of Treatment/Orders
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs
- Any lab results or other diagnostic procedures to support the diagnosis

AccuRx Infusion Center will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.