MRN: _______

Standard Plan of Treatment for Intralipids

Note: We may require MD office notes and may require a letter of Medical Necessity (depending on diagnosis), to be able to verify eligibility and payment for this treatment through patients Medicare and/or other insurance plan.

Patient's Name: _____ Weight: _____

Allergies:_____ Height: _____

Primary Diagnosis_____Secondary Diagnosis:_____

If adverse drug reaction, implement Adverse Drug Reaction Guidelines.

Order:

Infuse 4 ML 20% Intralipid Solution, in 250 ML Normal Saline over 45 minutes to 1 hour

Additives: _____

Physician Signature: _____ / _____ Date: _____

(Dispense as written) (Substitution Permitted)

Print Physician Name: _____

01/09/2017

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.