COMPASSUS®

ANTIBIOTIC INFUSION ORDERS

P: (414) 563-0505 | **F:** (414) 563-0600

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to (414) 563-0600

Patient Name: _____ DOB: _____ Phone: _____

Last 4 SS# digits _____ Patient Status: ☐ New ☐ Continuing Therapy Next Treatment Date:

INSURANCE INFORMATION: Please attach a copy of insurance cards (front and back)

MEDICAL INFORMATION

Patient Weight: _____ lbs. (required) Height: _____ Diabetic ☐ Yes ☐ No

Allergies: _____

Primary Diagnosis: _____ ICD-10: _____

Home infusion patients, please answer the following:

Has patient previously received this antibiotic? ☐ Yes ☐ No - If no, can first dose be given in the home ☐ Yes ☐ No

Arrange for first dose outpatient? ☐ Yes ☐ No Arrange for nursing? ☐ Yes ☐ No

Can we send the following: ☐ Diphenhydramine 25-50mg PO or IV PRN allergic reaction (adult)
☐ Epinephrine 1:1000, 0.3mL IM PRN severe allergic reaction (adult)
*Refer to prescriber orders for peds dosing

Does the patient have an IV line? ☐ Yes ☐ No - If no, arrange for PICC/midline? ☐ Yes ☐ No

Remove PICC/midline at the end of therapy? ☐ Yes ☐ No

THERAPY ORDER

☐ Acyclovir
☐ Amikacin
☐ Amphotericin B
☐ Ampicillin/Sulbactam (Unasyn)
☐ Avycaz
☐ Cefazolin
☐ Cefepime (Maxipime)
☐ Ceftazidime (Fortaz)
☐ Ceftriaxone (Rocephin)
☐ Cipro
☐ Clindamycin
☐ Cubicin
☐ Dalvance
☐ Doribax
☐ Fluconazole
☐ Gentamicin
☐ Imipenem/Cilastatin (Primaxin)
☐ Invanz
☐ Kimyrsa
☐ Levaquin
☐ Metronidazole (Flagyl)
☐ Merrem
☐ Mycamine
☐ Nafcillin
☐ Orbactiv
☐ Oxacillin
☐ Piperacillin/ Tazobactam (Zosyn)
☐ Teflaro
☐ Tigecycline
☐ Timentin
☐ Tobramycin
☐ Tygacil
☐ Vancomycin
☐ Vibativ
☐ Xerava

☐ Other: _____ ☐ Do not substitute

Dose: _____ mg _____ grams _____ mg/kg

Frequency: ☐ Daily ☐ Every 12 hours ☐ Every 8 hours ☐ One dose
☐ Every _____ hours ☐ Continuous over 24 hours ☐ Other: _____

Duration: _____ days _____ weeks **Route:** ☐ IV ☐ IM ☐ Other: _____

Flush orders: ☐ NS 1-20mL pre/post infusion PRN ☐ D5W 1-20mL pre/post infusion PRN
☐ Heparin 10U/mL per protocol as indicated ☐ Heparin 100U/mL per protocol as indicated

Lab orders: _____ **Frequency:** ☐ Weekly ☐ Other: _____

Other orders: _____ **Required labs to be drawn by:** ☐ Compassus ☐ Prescriber

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing *Compassus.* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: _____ Signature: Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

PREFERRED LOCATION

City: _____ State: _____

COMPASSUS®

COMPREHENSIVE SUPPORT FOR ANTIBIOTIC THERAPY

PATIENT INFORMATION:

Patient Name: _____ DOB: _____ Last 4 of SS#: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

☐ Include signed and completed order (MD/prescriber to complete page 1)

☐ Include patient demographic information and insurance information

☐ Include patient's medication list

☐ Supporting clinical notes (H&P) to support primary diagnosis

☐ Labs attached

☐ Culture results attached (if applicable)

☐ PICC/Central line placement confirmation (if applicable)

☐ Other medical necessity: _____

Compassus 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 refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (414) 563-0600 or call (414) 563-0505 for assistance.