

Ship to: Patient Physician / Clinic **Date Shipment Needed:** _____ **Rx:** New Refill _____

PATIENT INFORMATION	
Patient's Full Name: _____	Diagnosis: _____ ICD9 Code: _____
Address: _____	Patient Weight: _____ Height: _____
City, State, Zip: _____	Primary Insurance: _____
Home Phone: _____	ID #: _____ Phone: _____
Alternate Phone: _____	Secondary Insurance: _____
Patient's Social Security Number: _____	ID #: _____ Phone: _____
Patient's Date of Birth: _____	
Allergies: _____	
Patient's Gender (Male or Female): _____	
PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)	

IV MEDICATION	DIRECTIONS (Frequency of Administration)
<input type="checkbox"/> Ancef (Cefazolin) <input type="checkbox"/> Solu-Medrol (Methylprednisolone) <input type="checkbox"/> Cubicin (Daptomycin) <input type="checkbox"/> Unasyn (Ampicillin-sulbactam) <input type="checkbox"/> Invanz (Ertapenem) <input type="checkbox"/> Vancomycin (Vancocin) <input type="checkbox"/> Levaquin (Levofloxacin) <input type="checkbox"/> Zosyn (Piperacillin) <input type="checkbox"/> Maxipime (Cefepime) <input type="checkbox"/> IVIG (Immune Globulin) <input type="checkbox"/> Primaxin (Imipenem) <input type="checkbox"/> TPN (Parental Nutrition) <input type="checkbox"/> Rocephin (Ceftriaxone) <input type="checkbox"/> Other: _____	

NURSING	1st DOSE	LINE ACCESS
<input type="checkbox"/> AP NURSING _____ <input type="checkbox"/> AGENCY _____	<input type="checkbox"/> _____	<input type="checkbox"/> PICC <input type="checkbox"/> PERIPHERAL _____ <input type="checkbox"/> OTHER _____

ADDITIONAL IV THERAPY	SERVICES REQUESTED
PICC LINE CARE	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly Orders: _____
LABS	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly Orders: _____
WOUND CARE	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly Orders: _____
PHARMACOKINETIC DOSING	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly Orders: _____

SPECIAL IV INSTRUCTIONS

PRESCRIBER INFORMATION	
Physician's Name (Please Print): _____	NPI#: _____
Address: _____	License#: _____
City, State, Zip: _____	DEA#: _____
Phone: _____ Fax: _____	Contact Name: _____
Physician's Signature: _____	Date: _____

I authorize AmeriPharma Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.