IV Antimicrobials

Provider Order Form Rev. 07/2023

Please fax completed referral form & all required documents to (833) 786-0025

HEALIX INFUSION CARE

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

Patient Status: ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

ICD 10 Code Required

☐ _____, ICD10 _____ ☐ _____, ICD10 _____

INFUSION ORDERS

Antimicrobials will be dispensed in an elastomeric device (ED) for administration unless specified otherwise or as required by insurance.

☐ Ampicillin/Sulbactam ____ gm IV q6hr x ____ ☐ days ☐ weeks

☐ Amphotericin B Liposomal _____ mg IV q24hr x ____ ☐ days ☐ weeks

☐ Avycaz® 2.5 gm IV q8hr x ____ ☐ days ☐ weeks

☐ Cefazolin ____ gm IV q8hr x ____ ☐ days ☐ weeks

☐ Cefepime ____ gm IV q12hr x ____ ☐ days ☐ weeks

☐ Ceftriaxone ____ gm IV q24hr x ____ ☐ days ☐ weeks

☐ Dalvance® ☐ 1500 mg IV in-office x 1 dose

☐ 1500 mg IV in-office once weekly x ___ doses

☐ Other: _____

☐ Daptomycin _____ mg IV q24hr x ____ ☐ days ☐ weeks

☐ Ertapenem 1 gm IV q24hr x ____ ☐ days ☐ weeks

☐ Fetroja® 2 gm IV q8hr x ____ ☐ days ☐ weeks

☐ Kimyrsa® 1200 mg IV in-office x 1 dose

☐ Meropenem _____ mg IV q8hr x _____ ☐ days ☐ weeks

☐ Micafungin _____ mg IV q24hr x _____ ☐ days ☐ weeks

☐ Nafcillin ____ gm IV q ___ hr x ____ ☐ days ☐ weeks

☐ Nuzyra® 200 mg IV Day 1, then 100 mg IV q24hr x _____ ☐ days ☐ weeks

☐ Oxacillin ____ gm IV q ___ hr x ____ ☐ days ☐ weeks

☐ Piperacillin-Tazobactam ____ gm IV q ___ hr x ____ ☐ days ☐ weeks

☐ Recarbrio® 1.25 gm IV q6hr x ____ ☐ days ☐ weeks

☐ Teflaro® 600 mg IV q12hr x ____ ☐ days ☐ weeks

☐ Vabomere® 4 gm IV q8hr x ____ ☐ days ☐ weeks

☐ Vancomycin _____ mg IV q ___ hr x ____ ☐ days ☐ weeks

- Vancomycin trough: ☐ Before 4th dose ☐ Weekly ☐ Other _____

☐ Vibativ® _____ mg IV q24hr x ____ ☐ days ☐ weeks

☐ SCr every 48-72 hr for first 2 weeks of therapy

☐ Xerava® _____ mg IV q12hr x ____ ☐ days ☐ weeks

☐ Zerbaxa® 1.5 gm IV q8hr x ____ ☐ days ☐ weeks

☐ Other: _____

☐ Other: _____

Is patient currently receiving therapy above from another facility? ☐ NO ☐ YES

If yes, Facility Name: _____ Date of last treatment: _____ Date of next treatment: _____

OTHER ORDERS

LAB ORDERS: Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time

☐ CBC q _____ ☐ CMP q _____ ☐ CRP q _____ ☐ ESR q _____ ☐ LFTs q _____ ☐ Other: _____

ADDITIONAL ORDERS: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ Provider NPI: _____ Specialty: _____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

LAB AND TEST RESULTS (required)

☐ Culture and sensitivity report

☐ For patients currently receiving vancomycin or aminoglycosides: most recent labs and drug trough level

☐ Other: _____