# IV Antimicrobials

Provider Order Form Rev. 05/2024

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.**

**Long-acting Lipoglycopeptides**

☐ Dalvance® (In-office infusion)

**Single-dose regimen**

☐ 1500 mg IV over 30-60 minutes x 1 dose

☐ 1125 mg IV over 30-60 minutes x 1 dose

**Two-dose regimen**

☐ 1000 mg IV over 30-60 minutes once followed by 500mg IV over 30-60 minutes once week later

☐ 750 mg IV over 30-60 minutes once followed by 375mg IV over 30-60 minutes once week later

☐ Other: _____

☐ Kimyrsa® (In-office infusion)

☐ 1200 mg IV over 90-120 minutes x 1 dose

☐ Other: _____

**Antifungal**

☐ Rezzayo™ (In-office infusion)

☐ 400 mg IV x1 dose, followed by 200 mg IV once weekly x 3 doses

☐ Other: _____

**Other Antibiotics**

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

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

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

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

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

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

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

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

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

- Trough level: ☐ 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 ☐ Other: _____

☐ CBC q _____ ☐ CMP q _____ ☐ CRP q _____ ☐ CK q _____ ☐ ESR q _____ ☐ LFTs q _____

**ADDITIONAL ORDERS:** _____

## REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ NPI: _____ TIN: _____ 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

☐ For PICC lines: PICC line insertion report and tip placement verification

☐ Other: _____