## **IV Antimicrobials**

☐ Other: \_\_\_\_\_

Provider Order Form Rev. 05/2024
Please fax completed referral form & all required documents to (833) 786-0025



Patient Name:			EMOGRAPHICS		
NRCDA   Neight:	Patient Name:		DOB: Phone:		
Patient Status:   New to Therapy   Dose or Frequency Change   Order Renewal	Address:		City/ST/Zip:		
INSURANCE INFORMATION: Please attach copy of insurance card (front and back)  DIAGNOSIS*  INFUSION ORDERS  Antimicrobials will be dispensed in an elastomeric device (ED) for administration unless specified otherwise or as required by insurance.  Long-actina Lipophycopeptides  Antimipal  Delaviance® (in-office infusion)  Sensi-stass susteme  1 1500 mg IV over 30-60 minutes x 1 dose  1 1500 mg IV over 30-60 minutes x 1 dose  1 1500 mg IV over 30-60 minutes once followed by 500mg IV over 30-60 minutes once week later  1 750 mg IV over 30-60 minutes once followed by 375mg IV over 30-60 minutes once week later  1 1000 mg IV over 30-60 minutes once followed by 375mg IV over 30-60 minutes once week later  1 200 mg IV over 30-60 minutes once followed by 375mg IV over 30-60 minutes once week later  1 200 mg IV over 30-120 minutes once followed by 375mg IV over 30-60 minutes once week later  1 200 mg IV over 30-120 minutes x 1 dose  1 200 mg IV over 90-120 minutes x 1 dose  1 200 mg IV over 90-120 minutes x 1 dose  1 200 mg IV over 90-120 minutes x 1 dose  2 200 mg IV over 90-120 minutes x 1 dose  2 200 mg IV over 90-120 minutes x 1 dose  3 200 mg IV over 90-120 minutes x 1 dose  3 200 mg IV over 90-120 minutes x 1 dose  4 200 mg IV over 90-120 minutes x 1 dose  4 200 mg IV over 90-120 minutes x 1 dose  4 200 mg IV over 90-120 minutes x 1 dose  4 200 mg IV over 90-120 minutes x 1 dose  5 200 mg IV over 90-120 minutes x 1 dose  5 200 mg IV over 90-120 minutes x 1 dose  6 200 mg IV over 90-120 minutes x 1 dose  6 200 mg IV over 90-120 minutes x 1 dose  6 200 mg IV over 90-120 minutes x 1 dose  7 200 mg IV over 90-120 minutes x 1 dose  9 200 mg IV over 90-120 minutes x 1 dose  1 200 mg IV over 90-120 minutes x 1 dose  1 200 mg IV over 90-120 minutes x 1 dose  1 200 mg IV over 90-120 minutes x 1 dose  1 200 mg IV over 90-120 minutes x 1 dose  1 200 mg IV over 90-120 minutes x 1 dose  2 200 mg IV over 90-120 minutes x 1 dose  2 200 mg IV over 90-120 minutes x 1 dose  2 200 mg IV over 90-120 minutes x 1 dose  2 200 mg IV over	Allergies:		☐ NKDA Weight:		
DIAGNOSIS*   Required	Patient Status: ☐ New to	Therapy	ge		
INFUSION ORDERS		INSURANCE INFORMATION: Pleas	e attach copy of insurance ca	ard ( <u>front and back</u> ).	
Interest		DIA	AGNOSIS*		
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Congacting Lipodyconeptides     Rezzayo <sup>TM</sup> (In-office infusion)     Rezzayo <sup>TM</sup> (In-office infusion)   Rezzayo <sup>TM</sup> (In-office infusion)     Rezzayo <sup>TM</sup> (In-office infusion)     Rezzayo <sup>TM</sup> (In-office infusion)     Rezzayo <sup>TM</sup> (In-office infusion)     Rezzayo <sup>TM</sup> (In-office infusion)     Rezzayo <sup>TM</sup> (In-office infusion)     Rezzayo <sup>TM</sup> (In-office infusion)     Rezzayo <sup>TM</sup> (In-office infusion)     Rezzayo <sup>TM</sup> (In-office infusion)     Rezzayo <sup>TM</sup> (In-office infusion)     Rezzayo <sup>TM</sup> (In-office infusion)     Rezzayo <sup>TM</sup> (In-office infusion)     Rezzayo <sup>TM</sup> (In-office infusion)     Rezzayo <sup>TM</sup> (In-office infusion)     Rezzayo <sup>TM</sup> (In-office infusion)     Rezzayo <sup>TM</sup> (In-office infusion)     Rezzayo <sup>TM</sup> (In-office infusion)     Rezzayo <sup>TM</sup> (In-office infusion)     Rezzayo <sup>TM</sup> (In-office infusion)     Rezzayo <sup>TM</sup> (In-office infusion)     Rezzayo <sup>TM</sup> (In-office infusion)   Rezzayo <sup>TM</sup> (In-office infusion)   Rezzayo <sup>TM</sup> (In-office infusion)   Rezzayo <sup>TM</sup> (In-office infusion)   Rezzayo <sup>TM</sup> (In-office infusion)   Rezzayo <sup>TM</sup> (In-office infusion)   Rezzayo <sup>TM</sup> (In-office infusion)   Rezzayo <sup>TM</sup> (In-office infusion)   Rezzayo <sup>TM</sup> (In-office infusion)   Rezzayo <sup>TM</sup> (In-office infusion)	Antimiarabiala u			oified otherwice or as required by incurance	
□ Balvance® (th-office infusion)   Selected restances   □ 1125 mg   V over 30-60 minutes x 1 dose   □ 0 ther:   □ 0 ther:   □ 1125 mg   V over 30-60 minutes x 1 dose   □ 0 ther:   □ 0 t				chied otherwise or as required by misurance.	
Single-doze resilimen		<del></del> -		nfusion)	
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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 m	· ·				
Cityrsa® (In-office infusion)	□ 1000 mg IV over 3				
Other .	• .	·			
Other Antibiotics   Cefazolin	•				
Cefazolin					
Cefepime gm IV q12hr x		have Distriction		and IV a character of the second of	
Ceftriaxone					
□ Daptomycin mg  V q24hr x					
Ertapenem 1 gm IV q24hr x	=				
Meropenem	· · · ·				
Nuzyra® 200 mg IV Day 1, then 100 mg IV q24hr x	= -				
Piperacillin-Tazobactam		•	•		
Is patient currently receiving therapy above from another facility? Date of last treatment: Date of next treatment:    Date of next treatment: Date of	☐ Nuzyra® 200 mg IV Day 1	I, then 100 mg IV q24hr x □ days □ w	eeks		
If yes, Facility Name: Date of last treatment: Date of next treatment: Date of next treatment:	☐ Piperacillin-Tazobactam _	gm IV q hr x □ days □ weeks	Other:		
CAB ORDERS: Labs to be drawn by:   Infusion Center   Referring Physician   No labs ordered at this time   Other:   CK q   ESR q   LFTs q   ADDITIONAL ORDERS:    REFERRING PHYSICIAN INFORMATION	Is patient currently recei	iving therapy above from another facility?	□ NO □ YES		
LAB ORDERS: Labs to be drawn by:   Infusion Center   Referring Physician   No labs ordered at this time   Other:   CRP q   CRP q   ESR q   LFTs q   ADDITIONAL ORDERS:   Date:   Physician Signature:   Date:   Physician Name:   NPI:   TIN:   Specialty:   Specialty:   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	If yes, Facility Name:	Date	e of last treatment:	Date of next treatment:	
No labs ordered at this time		ОТНЕ	ER ORDERS		
No labs ordered at this time	LAB ORDERS: Labs	to be drawn by: ☐ Infusion Center ☐	Referring Physician		
REFERRING PHYSICIAN INFORMATION  Physician Signature: Physician Name: NPI: TIN: Specialty: Contact Person: 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		•	• •		
REFERRING PHYSICIAN INFORMATION  Physician Signature: Date:					
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					
Physician Signature:	ADDITIONAL ORDERS: _				
Physician Name: NPI: TIN: Specialty:		REFERRING PHY	YSICIAN INFORMATIC	DN	
Address:					
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	Physician Name:	NPI:	TIN:	Specialty:	
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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	Contact Person:	Phone #:		Fax #:	
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	Email Where Follow Up Docu	umentation Should Be Sent:			
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