Gout REFERRAL FORM

FAX REFERRAL TO: +1(844) 277-0049 **PHONE:** +1(844) 650-5802

IV Solutions RX

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ **DOB:** _____ **Gender:** ☐ MALE ☐ FEMALE
Address: _____ **City/State/Zip:** _____
Primary Phone: _____ **Email:** _____ **SSN:** _____ **Primary Language:** _____
Emergency Contact: _____ **Relationship to Patient:** _____ **Phone:** _____

2 INSURANCE *(Please attach **If Available** a copy of the Patients' insurance card(s) Front/ Back)*

Primary Insurance: _____ **Policy No:** _____ **Group:** _____
Primary RX Insurance:_____ **ID No:**_____ **RX GRP:**_____ **RX BIN:**_____ **RX PCN:**_____

3 DIAGNOSIS AND CLINICAL INFORMATION

First time receiving Therapy? ☐ Yes ☐ No **If No, previous product used:** _____ **Last Dose Given:** _____

Patient Clinical Information:

Diagnosis (ICD-10): ☐ M1A Chronic Gout ☐ Other DX: _____ Description: _____

Drug Allergies:_____ ☐ NKDA **Ht:** _____in/cm **Wt:** _____lbs/Kg

Labs: Please ensure labs are dated within 1 year of the patients referral request:
☐ **CMP** ☐ **CBCw/ diff** ☐ **Serum Uric Acid (sUA)** ☐ **G6PD Screen**

4 PRESCRIPTION INFORMATION

ACCESS: ☐ IV ☐ PORT ☐ Subcutaneous

MEDICATION	STRENGTH	DIRECTION	QUANTITY	REFILLS
☐ **Ilaris**	☐ 150 mg/mL	Inject 150 mg SC once	**(x1) Vial**	**(x1) Year**
☐ **Krystexxa**	☐ 8 mg/mL	Infuse 8 mg IV every 2 weeks	**Q.S**	**(x1) Year**
☐ **Other:** _____	☐ Other_____	Other_____	**Q.S**	**(x1) Year**

PRE/POST ORDERS:

MEDICATION	DIRECTION	QUANTITY	REFILLS
☐ Diphenhydramine **(PO)**	Administer _____ mg 30-60 min Prior to Infusion. May repeat every _____ hours PRN.	Quantity: **Q.S**	Refills: **PRN**
☐ Acetaminophen **(PO)**	Administer _____ mg PO 30-60 min Prior to Infusion. May repeat every _____ hours PRN.	Quantity: **Q.S**	Refills: **PRN**

ANAPHYLAXIS PROTOCOL:

MEDICATION	DIRECTION	QUANTITY	REFILLS
☒ EPINEPHRINE **(vial or autoinjector)**	Administer IM for severe anaphylactic reaction. May repeat in 5-15 minutes ☐ ***0.3 mg (Wt > 30 kg)*** ☐ ***0.15 mg (Wt 15-30 kg)*** ☐ ***0.1 mg (Wt 7.5-15 kg)***	Quantity: **(x1) Vial** or **(x2) Pen(s)**	Refills: **PRN**
☒ DIPHENHYDRAMINE **(50mg/mL)**	Administer via IM or slow IV push for severe anaphylactic reaction. ☐ ***50 mg (Wt > 30 kg)*** ☐ ***25 mg (Wt 15-30 kg)*** ☐ ***12.5mg (Wt 7.5-15kg)***	Quantity: **(x1) Vial(s)**	Refills: **PRN**
☒ SODIUM CHLORIDE 0.9% **(IV)**	Infuse 500 mL IV as directed for severe anaphylactic reaction.	Quantity: **500 mL**	Refills: **PRN**

NURSING/ LABS/ INFUSION SUPPLIES:

☒ **NURSING:** Nursing visits with each infusion to establish venous/port access, administer medication, assess and monitor patient, provide education, and complete lab draw
☒ **INFUSION SUPPLIES:** Infusion supplies and infusion pump PRN for the administration and disposal of medication.
FLUSHING PROTOCOL: ☐ Sodium chloride 0.9%, Up to 10 mL before/after medication, and/or PRN to maintain patency.
Heparin: ☐ 10 Units/mL ☐ 100 Units/mL, _____ as final flush and/or PRN to maintain patency

5 PRESCRIBER SIGNATURE REQUIRED *(STAMP SIGNATURE NOT ALLOWED)*

Prescriber Name: _____ **Title:** ☐ **MD** ☐ **DO** ☐ **ND** ☐ **PA** ☐ **APRN** **NPI:** _____
Address: _____ **City/State/Zip:** _____
Phone: _____ **Fax:** _____ **Contact Person:** _____

☐ **DISPENSE AS WRITTEN** ☐ **BRAND MEDICALLY NECESSARY** ☐ **DO NOT SUBSTITUTE**
☐ **NO SUBSTITUTION /** ☐ **DAW /** ☐ **MAY NOT SUBSTITUTE**

Prescriber's Signature: _____ **Date:** _____

☐ **May Substitute /** ☐ **Product Selection Permitted /** ☐ **Substitution Permissible**

Prescriber's Signature: _____ **Date:** _____

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution." NY & IA: electronic prescription required.

Prescribers are to comply with state-specific prescription regulations, which may include requirements for electronic prescribing, generic substitution, authorized prescription formats, and fax language. Noncompliance with these requirements may prompt follow-up communication with the prescriber.

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. I authorize IV Solutions RX and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future refills of the same prescription for the patient listed above. I understand that I can revoke the designation at any time by providing written notice to IV Solutions RX.

CONFIDENTIALITY NOTICE: The information contained in this transmission may contain confidential information, including patient information protected by federal and state privacy laws. It is intended only for the use of the person(s) named above. If not the intended recipient, you are hereby notified that any review, dissemination, distribution, or duplication of this communication is strictly prohibited. If you are not the intended recipient, please contact the sender by reply email to **info@ivsolutionsrx.com** and destroy all copies of the original message.

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