Specialty Pharmacy VA-Community Care (General) 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: Community Care Network-VA CCN **Veteran EDIPI:** _____ **Veteran ICN:** _____

VA Medical Center Name: _____ **City:** _____ **State:** _____ **Phone:** _____

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): _____ **Description:** _____

Drug Allergies: _____ ☐ NKDA **Ht:** _____ in/cm **Wt:** _____ lbs/Kg

4 PRESCRIPTION INFORMATION

ACCESS: ☐ IV ☐ PORT ☐ SC

RX INFORMATION: Our pharmacist will identify clinically appropriate brand *(Unless product is specifically specified at the time of referral)* and infusion rate per FDA guidelines. Clinically appropriate substitutions may be allowed based on availability or payor requirements. Round dose(s) to the nearest vial size. Official orders will be outlined with "May Infuse" +/- 3 days if scheduling needs arises, with insurance payor approval".

MEDICATION	STREGNTH	DOSE & DIRECTIONS	QUANTITY/REFILL	ROUTE
☐ Other:_____	Other:_____	Other:_____	Quantity:_____ Refill:_____	Other:_____
☐ Other:_____	Other:_____	Other:_____	Quantity:_____ Refill:_____	Other:_____
☐ Other:_____	Other:_____	Other:_____	Quantity:_____ Refill:_____	Other:_____
☐ Other:_____	Other:_____	Other:_____	Quantity:_____ Refill:_____	Other:_____

PRE/POST ORDERS:

MEDICATION	DIRECTION	QUANTITY	REFILLS
☐ SoluMedrol® **(IV)**	Give _____ mg prior to infusion via ☐ IV push ☐ diluted in _____ mL of NS over 30 min.	Quantity: _____	Refills: _____
☐ Diphenhydramine: ☐ PO ☐ IV ☐ Loratadine **(PO)**	Administer _____ mg 30-60 min Prior to Infusion. May repeat every _____ hours PRN.	Quantity: _____	Refills: _____
☐ Acetaminophen **(PO)**	Administer _____ mg PO 30-60 min Prior to Infusion. May repeat every _____ hours PRN.	Quantity: _____	Refills: _____
☐ Hydration: ☐ 0.9% NaCl ☐ LR	Infuse _____ mL of _____ solution ☐ before ☐ after infusion.	Quantity: _____	Refills: _____
☐ Emla® cream ***(30 grams)***	Apply topically 30 to 60 minutes prior to access.	Quantity: _____	Refills: _____

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: _____	Refills: _____
☐ 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: _____	Refills: _____
☐ SODIUM CHLORIDE 0.9% **(IV)**	Direction: _____	Quantity: _____	Refills: _____

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

☐ **LABS:** *[Dx code: Z79.899]*; Labs to be drawn by RN prior to infusion every _____ ☐ Week ☐ Month(s), as follows:
☐ **CMP** ☐ **CBC w/ diff** ☐ **ESR** ☐ **CK** ☐ **IgG Total** ☐ **IgG Subclasses 1-4** ☐ **Other:** _____

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**	☐ **May Substitute /** ☐ **Product Selection Permitted /** ☐ **Substitution Permissible**
Prescriber's Signature: _____ **Date:** _____	**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.
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THANK YOU FOR YOU TRUSTING US WITH YOUR PATIENTS SPECIALTY CARE #welcome to our family