BIOCARE INFUSION
ONCOLOGY & THERAPEUTICS

OB/GYN
INFUSION ORDERS

FAX: 470.922.3656 | **PHONE:** 470.377.6400

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 470.922.3656

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:**

MEDICAL INFORMATION

Patient Weight: _____ lbs. (required) Allergies: _____

THERAPY ORDER

Diagnosis	Infusion Orders
☐ Mild Hyperemesis (ICD-10: O21.0) ☐ Hyperemesis w/metobolic disturbance (ICD-10: O21.1) ☐ Other: _____ (ICD-10: _____)	☐ 1 Liter ☐ 2 Liters D5 .45 NS IV x 1 day ☐ 1 Liter ☐ 2 Liters NS IV x 1 day ☐ 1 Liter ☐ 2 Liters Ringers Lactate IV x 1 day ☐ 1 Liter ☐ 2 Liters D5/Ringers Lactate x 1 day ☐ **Zofran** 4mg IVP x ☐ **Zofran** 8mg IVP x 1 ☐ May repeat regimen x _____ days
☐ Iron Deficiency Anemi ☐ Other medical necessity: _____ (ICD-10: _____)	**If the patient has Aetna, Cigna, Humana, or UHC, the patient must try and fail Venofer first** ☐ **Venofer** 200mg IV - Administer 5 doses over a 14 day perio ☐ **Venofer** 200mg IV weekly x 5 dose ☐ **Injectafer** 15mg/kg IV - Give 2 doses at least 7 days apart not to exceed 1500mg (wt <50kg ☐ **Injectafer** 750mg IV - Give 2 doses at least 7 days apart not to exceed 1500mg (wt ≥50kg) ☐ **Monoferric** 20mg/kg IV x 1 dose (wt <50kg ☐ **Monoferric** 1000mg IV x 1 dose (wt ≥50kg)
☐ Pyelonephritis ☐ Complicated UTI ☐ Other: _____ (ICD-10: _____)	☐ Rocephin 1gm IV daily x 7 day ☐ Rocephin 2gms IV daily x 7 day ☐ Ivanz 1gm IV daily x 7 day ☐ Other: _____
☐ Migraines ☐ Other: _____ (ICD-10: _____)	☐ Zofran 4mg IVP x ☐ Zofran 8mg IVP x ☐ Reglan 10mg IV x ☐ May repeat migraine regimen x _____ days ☐ Mag sulfate 1 gram IV x ☐ Depacon 500mg IV x 1 ☐ DHE 45 1mg IV x 1 — Non-OB patients
☐ Other: _____ (ICD-10 _____)	☐ Other: _____

Lab orders: _____ **Lab Frequency:** _____

Required labs to be drawn by ☐ Biocare Infusion ☐ Referring Provider

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing *Biocare Infusion,* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

☐Opt out of Biocare Infusion selecting site of care (if checked, please list site of care):

PREFERRED LOCATION

City: _____ State: _____ *View our locations here:*

BIOCARE INFUSION
ONCOLOGY & THERAPEUTICS

COMPREHENSIVE SUPPORT FOR OB/GYN THERAPY

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- ☐ Include signed and completed order (MD/prescriber to complete page 1)
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's medication list
- ☐ Supporting clinical notes (H&P) to support primary diagnosis
- ☐ Labs attached
- ☐ CBC, Iron, Ferritin, Transferrin, TIBC (for iron orders) - **attach results**
- ☐ Baseline LFTs (for Depacon orders) - **attach results** *can draw with 1st infusion if not available
- ☐ Other medical necessity: _____

Biocare Infusion will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (470) 922-3656 or call (470) 377-6400 for assistance