



IV Anti-Infective (Antibiotic) Referral Form

Home Infusion Prescription & Referral

Patients / caregivers: complete sections 1–2 and give this form to your prescriber. Prescribers: complete sections 3–7, sign, and fax with attachments to 855-872-5872.

Referral type: ☐ New referral ☐ Renewal / re-order ☐ Dose or frequency change ☐ Discontinue therapy Needed by

Administer at: ☐ Patient's home ☐ Prescriber's office ☐ Infusion suite ☐ SNF / other ☐ Hold until notified Start date

1 PATIENT INFORMATION

Last name First name MI Date of birth Sex: ☐ M ☐ F
Street address City State ZIP
Primary phone Alternate phone Email Preferred language
Caregiver / emergency contact Relationship Phone **OK to leave voicemail?** ☐ Yes ☐ No

2 INSURANCE & BILLING INFORMATION

Attach copies of ALL insurance cards, front and back

Primary insurance Member ID Group # Plan phone
Subscriber name Subscriber DOB Relationship to patient Medicare ID (MBI) Medi-Cal CIN
Secondary insurance Member ID Group # Plan phone
Rx card (if separate) Rx ID RxBIN RxPCN RxGroup **Coverage:** ☐ Medicare ☐ Medi-Cal ☐ Commercial / PPO ☐ HMO / IPA
Prior authorization: ☐ Not started — Biologic to obtain ☐ Pending ☐ Obtained Auth # Valid dates IPA / case manager

3 PRESCRIBER & REFERRAL SOURCE

Prescriber name Credentials NPI State license #
Practice / group Phone Fax
Address City State ZIP
Office contact Direct phone / ext Contact email Supervising MD (if NP/PA)
Referral source (if different) Hospital / facility Discharge planner / case manager Phone Discharge date

4 DIAGNOSIS & CLINICAL INFORMATION

Check all that apply — codes below are common indications, not a substitute for the chart

Primary dx ICD-10 Description Secondary dx ICD-10 Description
☐ M86.- Osteomyelitis (specify site) ☐ E11.621 / L97.- Diabetic foot ulcer, infected ☐ J15.9 Bacterial pneumonia
☐ M46.2- Osteomyelitis of vertebra ☐ I33.0 Infective endocarditis ☐ K65.0 Peritonitis
☐ M00.9 Pyogenic arthritis ☐ A41.9 Sepsis, unspecified organism ☐ K75.0 Abscess of liver
☐ T84.5- Infection of joint prosthesis ☐ R78.81 Bacteremia ☐ G00.9 Bacterial meningitis
☐ T81.4- Infection following a procedure ☐ A49.02 MRSA infection ☐ G06.- Intracranial / intraspinal abscess
☐ L03.9- Cellulitis (specify site) ☐ N39.0 Urinary tract infection ☐ B37.- Candidiasis (specify site)
☐ L02.9- Cutaneous abscess ☐ N10 Acute pyelonephritis ☐ Other — enter primary dx above

Height in Weight lb / kg Date ☐ NKDA Allergies & reactions

Vascular access: ☐ None — needs placement ☐ Peripheral ☐ Midline ☐ PICC ☐ Port ☐ Tunneled CVC Lumens Date placed

Infection site / source Organism(s) Culture date ☐ Sensitivities attached ☐ Cultures pending

SCr CrCl WBC Lab date ☐ Dialysis days ☐ Pregnant / breastfeeding Hearing / renal / hepatic concerns

ID physician Phone Fax Follow-up appt Weekly labs followed by

Please attach: ☐ Face sheet ☐ Insurance cards (front & back) ☐ H&P / progress notes ☐ Medication list ☐ Cultures & sensitivities

☐ Discharge summary ☐ Recent labs (CBC, CMP, drug levels)

Patient name DOB Prescriber

5 ANTI-INFECTIVE ORDERS

One line per drug. Infuse per product labeling via rate-controlled device unless specified.

Drug 1		Dose		Route		Frequency		Infuse over		Start		Stop		Total days	
Drug 2		Dose		Route		Frequency		Infuse over		Start		Stop		Total days	
Drug 3		Dose		Route		Frequency		Infuse over		Start		Stop		Total days	
Drug 4		Dose		Route		Frequency		Infuse over		Start		Stop		Total days	

First dose: ☐ Already given in hospital / clinic Date / time of last dose ☐ First lifetime dose — RN to give in home with anaphylaxis kit Next dose due

Delivery: ☐ Biologic to select per drug stability & patient (elastomeric, ambulatory pump, IV push, gravity) Specify

Dose adjustment: ☐ Biologic pharmacist may adjust dose / interval per renal function & drug levels; prescriber notified ☐ Prescriber approval required

Line at end of therapy: ☐ Remove after last dose ☐ Keep in place ☐ Weekly dressing change ☐ Alteplase 2 mg PRN occlusion

6 LABS, NURSING & FOLLOW-UP

Labs: ☐ CBC w/ diff ☐ BMP ☐ CMP ☐ CK ☐ CRP / ESR ☐ LFTs ☐ Vancomycin trough / AUC ☐ Aminoglycoside peak / trough Other

Frequency: ☐ Weekly ☐ Twice weekly Other Level timing (e.g., before 4th dose) **Results to:** ☐ Prescriber ☐ ID physician

Nursing: ☐ Admission visit, teaching & first home dose ☐ Weekly visits: labs, line care, dressing

☐ RN to administer each dose ☐ Patient / caregiver self-administers after teaching

Other nursing orders / special instructions

Standing orders included with every referral unless declined: anaphylaxis kit per Biologic protocol (epinephrine, diphenhydramine, 0.9% NaCl), saline / heparin flushes per access device, dressing change kits, infusion pump or elastomeric devices and supplies, sharps container, ancillary refills for the duration of therapy.

☐ Decline / modify standing orders:

7 PRESCRIBER AUTHORIZATION

Original signature required — no stamps

I certify that the anti-infective therapy ordered above is medically necessary, that the patient is under my care, and that I will supervise the patient's treatment. Unless otherwise indicated, orders are valid for 12 months from the date signed. I authorize Biologic Infusion Pharmacy to act as my agent and on behalf of my patient to initiate and complete prior authorization, appeals, and related processes with the patient's health plan(s), including submission of any required forms and clinical documentation. Biologic may release medical information to the patient's health plan(s) and to the home health agency as needed to coordinate care. This authorization may be revoked in writing at any time.

Product selection: ☐ Substitution permitted — Biologic may select product per payer formulary / availability ☐ Dispense as written

Refills for the duration of therapy ordered above Verbal order taken by / date (pharmacy use)

Prescriber signature (no stamps)	Print name & credentials	Date

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