



Parenteral Nutrition (TPN) 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
☐ K91.2 Postsurgical malabsorption / short bowel ☐ K63.2 Fistula of intestine ☐ C78.6 Peritoneal carcinomatosis
☐ K90.9 Intestinal malabsorption, unspecified ☐ K31.84 Gastroparesis ☐ E43 Severe protein-calorie malnutrition
☐ K56.7 Intestinal obstruction, unspecified ☐ K86.1 Chronic pancreatitis ☐ E44.0 Moderate protein-calorie malnutrition
☐ K56.0 Paralytic ileus ☐ K91.1 Postgastric surgery syndromes ☐ E46 Malnutrition, unspecified
☐ K59.81 Ogilvie syndrome ☐ C16.9 Malignant neoplasm, stomach ☐ R63.4 Abnormal weight loss
☐ K50.9- Crohn's disease ☐ C25.9 Malignant neoplasm, pancreas ☐ R11.2 Nausea with vomiting
☐ K51.9- Ulcerative colitis ☐ C18.9 Malignant neoplasm, colon ☐ O21.1 Hyperemesis gravidarum

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

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

Usual weight Weight 6 mo ago BMI Albumin Prealbumin Lab date ☐ Pregnant

Current intake: ☐ NPO ☐ Clear liquids ☐ Diet as tolerated ☐ Enteral feeds Anticipated PN duration ☐ ≥ 90 days / indefinite

GI dysfunction & reason enteral (tube) feeding is not feasible — required for Medicare

Please attach: ☐ Face sheet ☐ Insurance cards (front & back) ☐ H&P / progress notes ☐ Medication list ☐ Nutrition assessment / RD note

☐ Labs: CMP, Mg, Phos, TG, prealbumin ☐ Documentation of GI dysfunction

Patient name DOB Prescriber

5 PARENTERAL NUTRITION ORDERS

PN requires central venous access (PICC, port, or tunneled CVC).

Management: ☐ Biologic pharmacist / dietitian to formulate & manage PN per protocol (formula faxed for approval) ☐ Prescriber-specified formula below

Goal kcal / day or kcal/kg Protein g/day or g/kg Total volume mL/day ☐ Fluid restriction ☐ Advance to goal over 2–3 days

Macronutrients (per day)

leave blank if Biologic-managed

Amino acids g/day AA product Dextrose g/day Max GIR mg/kg/min ☐ 3-in-1 (TNA) ☐ 2-in-1 + separate lipid

Lipid emulsion: ☐ Intralipid 20% ☐ SMOFlipid 20% ☐ Clinolipid 20% ☐ Omegaven 10% g/day or mL days/wk

☐ Standard premix instead: Clinimix / Clinimix E Kabiven / Perikabiven Volume mL/day Other / notes

Electrolytes & additives (per day)

☐ Standard electrolytes per Biologic protocol **or custom:** Na mEq K mEq Ca gluconate mEq Mg sulfate mEq Phosphate mmol

Cl : acetate ☐ Balanced per pharmacist ☐ Max acetate ☐ Max chloride ☐ Adult MVI 10 mL daily ☐ Trace elements (Tralement) 1 mL daily

☐ Regular insulin units/bag ☐ Famotidine mg ☐ Selenium mcg ☐ Zinc mg ☐ Vitamin K mg/wk Other

Infusion schedule

☐ Cyclic over hours, taper up / down min (default 60) ☐ Continuous 24 h Days / week Start time Start date

6 MONITORING, NURSING & SUPPLIES

Labs: ☐ Baseline CMP, Mg, Phos, CBC, TG, prealbumin ☐ Twice weekly until stable, then weekly ☐ Monthly TG, prealbumin, CRP, LFTs Other

☐ Fingerstick glucose ☐ Biologic pharmacist / RD may adjust electrolytes, vitamins, and rate per labs & protocol; changes communicated to prescriber

Nursing: ☐ Teach patient / caregiver pump, aseptic technique & line care ☐ Weekly RN visits: labs, dressing, assessment ☐ RN to hang each bag

☐ Daily weight, temperature & I/O log Other nursing orders

Supplies: ☐ Ambulatory pump & IV pole ☐ 1.2-micron filter tubing ☐ Line care kit & flushes per protocol ☐ Alteplase 2 mg PRN occlusion

Standing orders included with every referral unless declined: anaphylaxis kit per Biologic protocol, dressing change kits, flushes per access device, sharps container, ancillary refills × 12 months.

☐ Decline / modify standing orders:

7 PRESCRIBER AUTHORIZATION

Original signature required — no stamps

I certify that the parenteral nutrition 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 x 12 months unless otherwise noted Verbal order taken by / date (pharmacy use)

Prescriber signature (no stamps)

Print name & credentials

Date

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