

**Specialty Medication  
IV/SUBQ INFUSION  
PATIENT REFERRAL FORM**

Referral Fax: (304) 974-3341  
Referral Email: AHSHomeinfusion@wvumedicine.org  
Phone: (304) 974-3340  
If external referral (patient outside WVU Medicine),  
also attach a copy of patient demographics, insurance  
information, & pertinent clinical notes/labs.

ORDERING PROVIDER:		OFFICE CONTACT:	
OFFICE/ADDRESS:		PHONE:	FAX:
<b>PATIENT INFORMATION</b>			
NAME:		DOB:	SEX: <input type="checkbox"/> M <input type="checkbox"/> F
MRN:	PHONE:	ALLERGIES:	
ADDRESS:			
PRIMARY DIAGNOSIS AND CODE:			HT: <input type="checkbox"/> cm <input type="checkbox"/> in WT: <input type="checkbox"/> kg <input type="checkbox"/> lb
EMERGENCY CONTACT:		PHONE:	
<b>PRE-MEDICATIONS</b>		<b>PRN / EMERGENCY MEDICATIONS</b>	
<input type="checkbox"/> N/A <input type="checkbox"/> acetaminophen 650 mg ORAL once 30-60 minutes prior to infusion <input type="checkbox"/> diphenhydramine 25 mg ORAL once 30-60 minutes prior to infusion <input type="checkbox"/> methylprednisolone 125 mg IV once 30 minutes prior to infusion <input type="checkbox"/> hydrocortisone 100 mg IV once 30 minutes prior to infusion <input type="checkbox"/> other: _____		<input type="checkbox"/> epinephrine 0.5 mg IM once; may be repeated every 5-15 minutes, if needed, for 3 total doses <input type="checkbox"/> diphenhydramine 25-50 mg IV once if needed <input type="checkbox"/> hydrocortisone 100 mg IV once if needed <input type="checkbox"/> acetaminophen 325-650 mg ORAL once if needed <input type="checkbox"/> other / per provider protocol (specify & attach): _____	
<b>HOME INFUSION THERAPY</b>			
DRUG: _____		ROUTE: _____ PERIPHERAL IV OR _____ SUBCUTANEOUS X _____ (NUMBER OF) SITES	
DOSE: _____ mg/kg = total dose _____ mg		FREQUENCY: _____ WEEKLY, Q _____ DAYS, Q _____ WEEKS, OTHER: _____	
INFUSE OVER: _____ minutes or		RATE: _____	
END DATE: _____ or		DURATION OF THERAPY: _____ (circle one) DOSES / WEEKS / MONTHS	
DATE LAST DOSE GIVEN: _____			
PRE-INFUSION LABS: <input type="checkbox"/> N/A			
<input type="checkbox"/> Labs: _____			
<input type="checkbox"/> Frequency: _____			
SPECIFIC ADMINISTRATION INSTRUCTIONS: <input type="checkbox"/> N/A			
<input type="checkbox"/> Administer infusion per manufacturer guidelines			
<input type="checkbox"/> Other (if applicable): _____			
<b>NURSING ORDERS</b>			
<input type="checkbox"/> Infusion nurse visits to administer medication and assess & educate patient <input type="checkbox"/> Infusion nurse to start and remove peripheral IV access <input type="checkbox"/> Flush venous access with _____ ml of 0.9% NaCl before and after med administration, as appropriate <input type="checkbox"/> Stop infusion if hypersensitivity or infusion-related reaction develops, follow provider's EMERGENCY MEDICATION orders and nursing agency policy and procedure for anaphylactic /adverse reaction, and notify provider. <input type="checkbox"/> Educate patient on s/s of reaction and monitor patient for at least _____ minutes post infusion for any reactions <input type="checkbox"/> Other (if applicable): _____			
<b>PRESCRIBING PHYSICIANS SIGNATURE</b>		<b>NPI</b>	<b>DATE</b>
_____ The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize Allied Health Solutions and/or its affiliates to complete and submit prior authorization (PA) requests to payers for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.			

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