

Please complete each section of the referral form below and fax to OptiMed along with a copy (front and back) of all the patient's pharmacy and medical insurance cards, the patient's demographic face sheet, and any relevant clinical notes/documents.

Prescriber Information	<p>Prescriber: _____ NPI: _____</p> <p>Phone: _____ Fax: _____ Office Contact: _____</p> <p>Address: _____</p>
Patient Information	<p>Name: _____ DOB: _____ <input type="checkbox"/> M <input type="checkbox"/> F</p> <p>Address: _____</p> <p>Phone: _____ 2nd Phone: _____ SSN: _____</p> <p>Primary Language: _____ Functional Limitations: _____</p>
Clinical Information	<p>Diagnosis (include ICD-10 code): _____</p> <p>Weight: _____ <input type="checkbox"/> lb <input type="checkbox"/> kg Height: _____ <input type="checkbox"/> in IV access: <input type="checkbox"/> PIV <input type="checkbox"/> PICC <input type="checkbox"/> Port <input type="checkbox"/> Other: _____</p> <p>Patient's first dose? <input type="checkbox"/> Yes <input type="checkbox"/> No; date of last dose _____; prior dose (in mg) _____</p> <p>Allergies: _____ Latex allergy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Prior treatments & reason for discontinuation: _____</p> <p>History of kidney disease: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, SCr: _____ GFR/CrCl: _____ History of heart failure: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Additional Notes: _____</p> <p>Referring provider's preferred site of care*: <input type="checkbox"/> OptiMed Infusion Center <input type="checkbox"/> Home Infusion* <input type="checkbox"/> OptiMed to determine site of care</p> <p><small>*Site of care preference is subject to payer limitations, clinical appropriateness, and the availability of servicing providers.</small></p>
Prescription Information	<p>Medication: _____ Dose: _____ Route: _____ Frequency: _____</p> <p>Based on the clinical judgement of the pharmacist, doses may be rounded up or down by no more than 10% unless checked here: <input type="checkbox"/></p> <p>Quantity (# of doses/infusions): _____</p> <p>Preparation and Administration (please select one):</p> <p><input type="checkbox"/> OptiMed to determine diluent (when required) and rate of administration per the product package insert.</p> <p><input type="checkbox"/> Specific diluent/rate required: Diluent: _____ Rate of Administration: _____</p> <p>Nursing and Supplies: OptiMed to provide supply items and nursing care to prepare and administer product as per package instructions.</p> <p>Premedication orders: _____</p> <p>PRN medication orders: _____</p> <p>Lab orders: List any outpatient laboratory work related to this therapy you would like OptiMed to draw in conjunction with the patient's medication administration, including the frequency for each lab order. Lab orders are good for the life of the prescription order (one year) unless otherwise indicated. (Lab orders are subject to availability.)</p> <p>_____</p> <p>_____</p>
Prescriber Signature	<p>My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize OptiMed and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide infusion-related nursing services and supplies in conjunction with the therapy prescribed above.</p> <p>Signature: _____ Date: _____</p>

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