HOME INFUSION PRESCRIPTION

SPECIALTY INFUSION

Dothan, AL toll free fax 888.889.6702 toll free 866.580.8100

krogerspecialtyinfusion.com

NEEDS BY DATE: _____

PATIENT INFORMATION

Patient Name		Parent/Guardian *(if applicable)*	☐ All Insurance Info Attached
Address		City	State / Zip
Main Phone	Alternate Phone	Email Address	
Date of Birth	☐ Male ☐ Female	Height *(required)* inches	Weight *(required)* pounds
Allergies		Diabetic: ☐ Yes ☐ No	

MEDICAL INFORMATION

Primary Diagnosis: _____ ICD-10 Code: _____

Home Health Agency: _____

PRESCRIPTION AND ORDERS

Medication: _____ Dose: _____ Frequency: _____ Duration: _____

Medication: _____ Dose: _____ Frequency: _____ Duration: _____

Medication: _____ Dose: _____ Frequency: _____ Duration: _____

Pharmacy to dose based on current lab results? ☐ Yes ☐ No Administer first dose? ☐ Yes ☐ No

1. IV Access: Set Up Placement? ☐ Yes ☐ No

   a) _____ PICC Lines: Weekly dressing changes unless integrity of dressing changes or becomes soiled. Securing device to be used unless line is sutured in. Flush with 10mL NS before and after each use and weekly when not in use. If administering TPN or drawing labs flush with 20mL NS after use. May use 5mL Heplock flush 100 unit/mL for sluggish line. Use only 10mL syringe or larger.

   b) _____ Midline Catheter: Weekly dressing changes unless integrity of dressing changes or becomes soiled. Securing device to be used unless line is sutured in. Flush with 10mL NS before and after each use and weekly when not in use. If administering TPN or drawing labs flush with 20mL NS after use. May use 5mL Heplock flush 100 unit/mL for sluggish line. Use only 10mL syringe or larger.

   c) _____ Peripheral IV: Dressing change at site rotation every 72-96 hours or when clinically indicated. Flush with 5-10mL NS before and after each use. May use 3mL Heplock flush 10 unit/mL.

2. Anaphylaxis Protocol: Epinephrine 0.3mg IM / Diphenhydramine 25-50mg by mouth PRN.

3. Labs Needed: _____ Frequency: _____

4. May discharge patient when therapy complete.

PHYSICIAN INFORMATION

Physician Name: _____ License: _____

Address: _____ DEA: _____

City: _____ State: _____ Zip: _____ NPI: _____

Phone: _____ Fax: _____ Office Contact *(required)*: _____

STATEMENT OF MEDICAL NECESSITY: This is a patient who is in need of antibiotics in the home setting. Kroger Specialty Infusion Pharmacist will dispense medications as ordered by Physician.

By signing this form and utilizing our services, you are authorizing Kroger Specialty Infusion and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

_____ _____ _____ _____

Prescriber's Signature (no stamps) Substitution Permitted Date Prescriber's Signature (no stamps) Dispense As Written Date

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