

## Patient Information

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Email: \_\_\_\_\_ Weight: \_\_\_\_\_  lbs  kgs  
Allergies:  NKDA  \_\_\_\_\_

**Required Documentation** Insurance Card | History & Physical | Patient Demographics | Most Recent Labs | Medication List

## Primary Diagnosis

ICD-10 Code: \_\_\_\_\_

## Order Information

### Lab Orders (Include frequency)

Please list any labs to be drawn by the infusion clinic: \_\_\_\_\_

### Pre-Medications

Provider Prescribed: \_\_\_\_\_

### Primary Medication Order

Please include *medication, dose, route, frequency, duration*, and any additional administration instructions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

First Dose:  Yes  No  Refill x12 months unless otherwise noted: \_\_\_\_\_

### Line Use/Care Orders

Start PIV/ACCESS CVC  Flush device per BluHaven Health's protocol (see BluHaven.com for policy)  
 Other Flush Orders: Please fax other line care orders if checking this box.

### Adverse Reaction & Anaphylaxis Orders

Administer acute infusion reaction and anaphylaxis medications per BluHaven Health's protocol (see BluHaven.com for policy)  
 Other: Please fax other reaction orders if checking this box.

## Provider Information

Name: \_\_\_\_\_ Office Contact: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
Email: \_\_\_\_\_ NPI: \_\_\_\_\_

I authorize BluHaven Health and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this order and any future related orders for the patient listed above.

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date