

# LOTUS HEALTH HOUSTON INFUSIONS

3569 BUSINESS CENTER DR SUITE 160  
PEARLAND, TEXAS 77584

# OB/GYN ORDER FORM

P: 832.284.4452 | F:877.643.0993

## PATIENT INFORMATION

☐ Demographics attached

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

**INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)**

## MEDICAL INFORMATION

Patient Weight: \_\_\_\_\_ lbs. Allergies: \_\_\_\_\_

☐ Clinical/Progress Notes, Labs, and Tests supporting primary diagnosis attached

**Labs:** Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

**Lab Orders:** \_\_\_\_\_

## INFUSION ORDERS

DIAGNOSIS	INFUSION ORDERS	REFILLS
<input type="checkbox"/> Hyperemesis: _____	<input type="checkbox"/> 1 Liter/ <input type="checkbox"/> 2 Liters D5 .45% NS IV x 1 day <input type="checkbox"/> 1 Liter/ <input type="checkbox"/> 2 Liters NS IV x 1 day <input type="checkbox"/> Zofran 4mg IV <input type="checkbox"/> 1 Liter/ <input type="checkbox"/> 2 Liters Ringers Lactate IV x 1 day <input type="checkbox"/> Zofran 8mg IV <input type="checkbox"/> 1 Liter/ <input type="checkbox"/> 2 Liters D5/Ringers Lactate x 1 day	<input type="checkbox"/> _____
<b>Primary ICD-10</b> <input type="checkbox"/> Iron Deficiency Anemia: _____ <input type="checkbox"/> Iron Deficiency Anemia with CKD not on dialysis: _____ <input type="checkbox"/> Other medical necessity: _____  <b>Required Recent Labs: HGB, HCT, TIBC, Ferritin</b>	<b>Last Iron dose</b> (if applicable) _____ <b>Secondary ICD-10</b> <input type="checkbox"/> Adverse Effect of other drug _____ ( <i>Oral iron intolerance or not adequate</i> ) <input type="checkbox"/> Other medical necessity: _____ <input type="checkbox"/> <b>Venofer</b> 200mg IV q 3 weeks x 5 doses <input type="checkbox"/> <b>Venofer</b> 100mg IV q week x 7 weeks then every other week x 7 weeks (10 doses total) <input type="checkbox"/> <b>Venofer</b> 200mg IV - Administer 5 doses over a 14 day period <input type="checkbox"/> <b>Venofer</b> 200mg IV weekly x 5 weeks <input type="checkbox"/> <b>Injectafer</b> 15mg/kg IV - Give 2 doses at least 7 days apart not to exceed 1500mg <i>if patient weighing less than 50kg (110lbs.)</i> <input type="checkbox"/> <b>Injectafer</b> 750mg IV - Give 2 doses at least 7 days apart not to exceed 1500mg <i>if patient weighing 50kg (110lbs.) or greater</i>	<input type="checkbox"/> _____
<input type="checkbox"/> Pyelonephritis: _____ <input type="checkbox"/> Complicated UTI: _____ <b>Required Labs: CBC, BMP</b>	<input type="checkbox"/> Rocephin 1gm IV daily x 7 days <input type="checkbox"/> Rocephin 2gms IV daily x 7 days <input type="checkbox"/> Invanz 1gm IV daily x 7 days	<input type="checkbox"/> _____
<input type="checkbox"/> Migraines: _____ <b>Required Labs: LFTs if ordering Depacon treatment</b>	<input type="checkbox"/> Zofran 4mg IV <input type="checkbox"/> Magnesium Sulfate 1gm IV <input type="checkbox"/> Zofran 8mg IV <input type="checkbox"/> Depacon 500mg IV <input type="checkbox"/> Reglan 10mg IV <input type="checkbox"/> DHE 45 1mg IV	<input type="checkbox"/> _____

## PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing LOTUS HEALTH HOUSTON and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: \_\_\_\_\_ Physician Name: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Contact Person: \_\_\_\_\_