Hunt Regional Infusion Center
903-408-5840 (phone)
903-455-8773 (fax)

GENERAL IV PRESCRIPTION ORDER FORM

PATIENT INFORMATION

Last Name:_____ First Name:_____ MI_____

HT: _____ WT: _____ DOB:_____ Sex: ( ) Male ( ) Female SSN: _____

Street Address_____ City/State/Zip_____

Home Phone #:_____ Work #:_____ Cell #: _____

Allergies:_____

INSURANCE INFORMATION

Primary Insurance Name_____ Policy #: _____

Secondary Insurance Name_____ Policy #: _____

PHYSICIAN / FACILITY INFORMATION

Physician's Name_____ Contact Name_____ Contact Phone # _____

Street Address_____ City/State/Zip_____

DEA#:_____ NPI #:_____ Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD-10 Code plus Description)

_____

Date of Diagnosis: _____

Does the patient have venous access? O Yes O No If Yes, what type? _____

If No, does patient need venous access? O Yes O No If Yes, please specify in the prescription orders.

PRESCRIPTION ORDERS

Labs Needed: _____

"Pharmacy law may permit pharmacists to substitute a less expensive FDA-approved generically equivalent medication or biosimilar for a brand-name medication or prescribed biologic unless the practitioner indicates otherwise by writing "brand necessary" or "brand medically necessary" on the prescription."

☐ DO NOT ADMINISTER HEPARIN TO THIS PATIENT –

UNLESS THE BOX IS CHECKED ALL PICC LINES, MIDLINES, AND CENTRAL LINES MAY BE FLUSHED WITH *HEPARIN 300unit/3mL*

Physician's Signature _____ **Date:**_____ **Time:**_____

Fax completed form to Hunt Regional Infusion Center at (903) 455-8773. PLEASE include copies of ALL patients' current insurance cards to expedite benefit verification. Also forward any lab work, Letter of Medical Necessity and any other supporting documentation supporting the use of Infusion Therapy.