

For therapies not listed on our website (MEDIXINFUSION.COM/FORMS), please use this form to submit an inquiry on the required medication. Our formulary team will review and contact you with a determination on our ability to administer the medication and any additional documentation required.

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: M / F Ht: _____ Wt: _____ lbs / kg
 Primary Language: _____ Allergies: _____
 Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

<ICD 10 CODE REQUIRED>

ICD 10 Code

ICD 10 Code: _____

Description: _____

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.
LAB RESULTS: Please include lab results to support diagnosis.

PRESCRIPTION

Pre-Medications

- ☐ Acetaminophen: 650 mg PO
- ☐ Cetirizine: 10 mg PO
- ☐ Diphenhydramine: 25 mg PO
- ☐ Diphenhydramine: 25 mg IVP
- ☐ Famotidine: 20 mg PO
- ☐ Methylprednisolone: 125 mg SIVP
- ☐ Ondansetron: 4 mg ODT
- ☐ Ondansetron: 4 mg IVP

Other: _____

Other: _____

Medication to Order: _____

Dose: _____

Route: _____

Frequency: _____

Duration: _____

Lab Orders

Lab: _____ Frequency: _____

Lab: _____ Frequency: _____

Lab: _____ Frequency: _____

In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reaction protocol.

Comments: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ **Signature:** _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____