Curbside Infusion

Vyepti Order Form

.. Please fax form to: 281-406-1047
or email to referrals@curbsideinfusion.com

Patient Information

Patient Name:	DOB:	Phone:	Gender: M☐ F☐
Patient Address:	Email:	Insurance:	

Additional Information Needed

☐ Fax front/back of insurance card ☐ Fax clinical/progress notes ☐ Fax labs
☐ Fax patient demographics ☐ Fax current medication list ☐ Fax TB and Hep B results

Diagnosis and Clinical Information

Diagnosis (ICD-10):
☐ Code: _____ Description: _____
☐ Code: _____ Description: _____
☐ Code: _____ Description: _____

☐ **Clinical Information:**
☐ New Therapy Induction ☐ Therapy Change ☐ Therapy Continuation
☐ Patient Weight: _____ lbs / _____ kg ☐ Patient Height: _____ in / _____ cm
☐ Allergies: _____
☐ Therapies Tried and Failed: _____

Lab Orders

☐ CBC ☐ CMP
☐ Other: _____

Lab Orders to be done by

☐ Curbside Infusion Services
☐ Referring Provider

Prescription Information

☐ Vyepti
☐ Dose: 100mg
☐ Dose: 300mg
☐ Frequency: every 3 months

Pre-Medication Orders

☒ Tylenol tablet 500-1000mg PO PRN ☐ Other: _____

Standing Orders for Adverse Reactions

☒ Stop infusion and initiate NS bolus
☒ Notify supervising physician and ordering provider
☒ Solu-Cortef 100mg SIVP signs of adverse reaction
☒ Benadryl 25mg SIVP for hives or bronchial inflammation
☒ Epi 1:1000 1mL IM, IV, or SQ for anaphylaxis
☒ Oxygen 2-5L nasal cannula
☒ Albuterol 2.5mg inhaled PRN for chest tightness
☐ Other: _____

Prescriber Information

Prescriber Name:		Office Contact Name:	
NPI #:	DEA #:	Contact Phone:	Contact Fax:

_____ _____
Prescriber's Signature: **Date:**

By signing this form, you are authorizing Curbside Infusion Venture, LLC dba Curbside Infusion Services and its employees to act as your designated agent to interact with medical and prescription insurance companies for prior authorization and specialty pharmacy approval to render infusion services.