Order Form

POLARIS INFUSION

931 Buena Vista St., Suite 205, Duarte, CA 91010

Date:

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ **Patient Phone:** _____ **DOB:** _____

ICD-10 code (required): ☐ _____ **ICD Description:** _____

Allergies: _____ **Height:** _____ **Weight (lbs/kg):** _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ **Next Due Date:** _____

PROVIDERS: Please include the following to expedite the order:
Patient Demographics, Most Recent Office Visit Note, Insurance Information

PROVIDER INFORMATION

Referral Coordinator Name: _____ **Referral Coordinator Email:** _____

Ordering Provider: _____ **Provider NPI:** _____

Referring Practice Name: _____ **Phone:** _____ **Fax:** _____

Practice Address: _____ **City:** _____ **State:** _____ **Zip:** _____

NURSING

☐ Center will use Hypersensitivity protocol established by Polaris Infusion.

☐ Other:

_____

PRE-MEDICATION ORDERS

☐ Diphenhydramine ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV

☐ Acetaminophen ☐ 325mg / ☐ 500mg / 650mg ☐ PO

☐ Nacl 0.9%, infuse_____MLs IV over_____Mins/Hrs

☐ Other:

_____

SPECIAL INSTRUCTIONS

NURSING

☐ CBC ☐ at each dose ☐ every_____

☐ CBC w/ differential ☐ at each dose ☐ every_____

☐ BMP ☐ at each dose ☐ every_____

☐ CMP ☐ at each dose ☐ every_____

☐ Other_____ ☐ Frequency:_____

☐ Please check this box if you DO NOT authorize Polaris Infusion to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

THERAPY ADMINISTRATION

☐ Medication: _____

Route: ☐ intravenous ☐ subcutaneous ☐ intramuscular

Dose: _____

Frequency: _____

Duration: _____

☐ Refills: ☐ Zero/ ☐ for 12 months/ ☐_____
(if not indicated order will expire one year from date signed)

To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, Polaris Infusion is authorized to administer a generic or biosimilar.

_____ _____ _____

Provider Name (Print) Provider Signature Date

☐ Please check this box if you DO NOT authorize Polaris Infusion to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.