



FAX: 800-987-6552
Phone: 877-283-8679

TPN ORDER

PATIENT INFORMATION

Patient Name:	Ship to: <input type="checkbox"/> Home <input type="checkbox"/> Office	DOB:
Home Address:	City:	State: Zip:
Home Phone:	Height:	Weight: Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Cell Phone:	Email Address:	

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance Co:	Policy Holder:	Relationship:	Policy#:	Group#:
Secondary Insurance:	Policy Holder:	Relationship:	Policy#:	Group#:

CLINICAL INFORMATION (fax all pertinent clinical and lab information)

Diagnosis (ICD-10):	Date of Diagnosis:	List of Other Nutritional Therapies:
Is patient TPN dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No	Central Access Placed:	Type of Access: <input type="checkbox"/> PICC <input type="checkbox"/> Hickman/Broviac <input type="checkbox"/> Groshong <input type="checkbox"/> Port
List additional comorbidities:	Allergies:	

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Medication Orders	Days Per Week _____	Cyclic: Infuse over _____ hours	<input type="checkbox"/> Taper up and down x 1 hour
		Continuous (24 hours/day)	<input type="checkbox"/> Taper up x _____ hrs Taper down x _____ hrs
Macronutrient Components:	<input type="checkbox"/> Clinimix (5/15) 2000 ml Amino Acids 5% / Dextrose 15% 1490 kCal (Recommended for patients >65 kg)	<input type="checkbox"/> Clinimix (4.25/10) 2000 ml Amino Acids 4.25% / Dextrose 10% 1020 kCal (Recommended for patients <65 kg)	<input type="checkbox"/> Custom Formula Amino Acids (4 kCal/gm) _____ % Dextrose (3.4 kCal/gm) _____ % Volume (excludes lipids) _____
	Lipids (20%) Frequency:	<input type="checkbox"/> 250 ml/day (500 kcal/day)	<input type="checkbox"/> _____ ml/day
Electrolytes	<input type="checkbox"/> Daily <input type="checkbox"/> Twice weekly <input type="checkbox"/> Three times weekly <input type="checkbox"/> Other: _____	Standard Sodium 35 mEq/L Potassium 30 mEq/L Magnesium 5 mEq/L Calcium 4.5 mEq/L Phosphate 15 mMol/L Acetate 80 mEq/L Chloride 39 mEq/L	
		Custom (specify amount of each electrolyte) Na: _____ mEq (60-100 mEq) K: _____ mEq (60-100 mEq) Mg: _____ mEq (10-20 mEq) Ca: _____ mEq (9-18 mEq) Phosphate: _____ mEq (20-30 mEq) Acetate: _____ mEq (0-100 mEq) Chloride: _____ mEq	
Additives	<input type="checkbox"/> Multivitamin (MVI-12)* <input type="checkbox"/> 10ml/day <input type="checkbox"/> _____ ml/day	*To be added immediately before administration **Trace elements per 1 ml: Zinc 5 mg, Copper 1 mg, Manganese 0.5 mg, Chromium 10 mcg, and Selenium 60 mcg IV Hydration Orders: Solution: _____ Volume: _____ Rate: _____ Frequency: _____	
	<input type="checkbox"/> Trace Elements** <input type="checkbox"/> 1 ml/day <input type="checkbox"/> _____ ml/day <input type="checkbox"/> Regular Insulin* _____ units/day <input type="checkbox"/> Famotidine* _____ mg/day <input type="checkbox"/> Ranitidine* _____ mg/day <input type="checkbox"/> Other: _____		
Line Flushing and Additional Orders	Alteplase 2 mg - IV per protocol PRN for occluded line	Sodium Chloride 0.9% 5-10 mL pre and post medication and prn	
	Lidocaine/Prilocaine 2.5%/2.5% Cream - topically PRN	Heparin 10 units/ml: 3 ml after last NaCl 0.9% flush and prn	
	Other: _____	Heparin 100 units/ml: 5ml after last NaCl 0.9% flush and prn	

Clinical Pharmacist to monitor labs and adjust formula as needed.

Labs:	<input type="checkbox"/> CBC with Diff <input type="checkbox"/> weekly <input type="checkbox"/> every _____	Blood Glucose Monitoring:
	<input type="checkbox"/> CMP <input type="checkbox"/> weekly <input type="checkbox"/> every _____	
	<input type="checkbox"/> Magnesium <input type="checkbox"/> weekly <input type="checkbox"/> every _____	<input type="checkbox"/> Twice daily (for continuous infusion)
	<input type="checkbox"/> Phosphorus <input type="checkbox"/> weekly <input type="checkbox"/> every _____	<input type="checkbox"/> 1 hour before infusion (for cyclic infusion)
	<input type="checkbox"/> Pre-albumin <input type="checkbox"/> weekly <input type="checkbox"/> every _____	<input type="checkbox"/> 2 hours into infusion (for cyclic infusion)
	<input type="checkbox"/> Other: _____ <input type="checkbox"/> weekly <input type="checkbox"/> every _____	<input type="checkbox"/> With routine labs (if stable)
		<input type="checkbox"/> Other: _____

Pump and Ancillary Supplies Provide pump and supplies as needed for dilution, administration, and appropriate disposal of infusion materials.

Skilled Nursing Orders and Plan of Treatment Provide skilled nursing for home infusion training, dressing changes, and lab draws PRN.
 Independent; no nursing needed.

Administration procedures to be followed per pharmacy protocol or manufacturer's guidelines. Refill (all orders above) x 1 YEAR OR _____ times

PHYSICIAN INFORMATION

Prescriber Name:	Phone:	Fax:
Office Contact:	Email Address:	
Address:		
NPI:		
Prescriber Signature:	Date:	

Your signature authorizes AvevoRx, LLC and their network of pharmacies, Mid-Valley Health System (the "AvevoRx Pharmacies"), to act on your behalf to obtain prior authorization, including appeals and peer to peer reviews, for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients.

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