TPN Referral Form

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

PATIENT INFORMATION

Patient Name:	Ship to: ☐ Home ☐ Office		DOB:
Home Address:	City:		State: / Zip:
Home Phone:	Height:	Weight:	Gender: ☐ Male ☐ 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? ☐ Yes ☐ No	Central Access Placed:	Type of Access: ☐ PICC ☐ Hickman/Broviac ☐ Groshong ☐ Port
List additional comorbidities:		Allergies:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Medication Orders	Days Per Week _______________	☐ Cyclic: Infuse over _______ hours	☐ Taper up and down x 1 hour
		☐ Continuous (24 hours/day)	☐ Taper up x ____ hrs Taper down x ___ hrs
Macronutrient Components:	☐ Clinimix (5/15) 2000 ml Amino Acids 5% / Dextrose 15% 1490 kCal (Recommended for patients >65 kg)	☐ Clinimix (4.25/10) 2000 ml Amino Acids 4.25% / Dextrose 10% 1020 kCal (Recommended for patients <65 kg)	☐ Custom Formula Amino Acids (4 kCal/gm)____________% Dextrose (3.4 kCal/gm) ______________% Volume (excludes lipids) ___________
Lipids (20%) Frequency:	☐ 250 ml/day (500 kcal/day)	☐ _________________ml/day	
	☐ Daily ☐ Twice weekly	☐ Three times weekly	☐ Other:_______________________________
Electrolytes	☐ **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	☐ Multivitamin (MVI-12)* ☐ 10ml/day ☐ _____ml/day ☐ Trace Elements** ☐ 1 ml/day ☐ _____ml/day ☐ Regular Insulin* __________units/day ☐ Famotidine* ____________mg/day ☐ Ranitidine*_____________mg/day ☐ Other: ____	*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: _______	
Line Flushing and Additional Orders	Alteplace 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:	☐ CBC with Diff ☐ weekly ☐ every________________ ☐ CMP ☐ weekly ☐ every________________ ☐ Magnesium ☐ weekly ☐ every________________ ☐ Phosphorus ☐ weekly ☐ every________________ ☐ Pre-albumin ☐ weekly ☐ every________________ ☐ Other: _____ ☐ weekly ☐ every ________________	**Blood Glucose Monitoring:** ☐ Twice daily (for continuous infusion) ☐ 1 hour beforeinfusion (for cyclic infusion) ☐ 2 hours into infusion (for cyclic infusion) ☐ With routine labs (if stable) ☐ 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.

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately by calling 866.442.4679 or by emailing jdent@avevorx.com to obtain instructions as to proper destruction of the transmitted material. Thank you.

***Referral forms are not considered legal prescriptions for certain payers and in certain states, including AL. AvevoRx, or it's partner pharmacies may request additional prescription orders where required by local state Board of Pharmacy regulations or specific payer restrictions.