Baxdela (delafloxacin)

Provider Order Form *rev. 1/2/2025*

AMERICAN INFUSION CARE
SPECIALTY INFUSION

PATIENT INFORMATION

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

Patient Full Name: _____ DOB:_____ Phone: _____ Gender: ☐ M ☐ F ☐ Other

Email Address: _____ Address: _____ Weight (lbs/kg): _____ Height (in): _____

☐ NKDA Allergies: _____ Existing prior authorization? ☐ Yes, (Send a copy) ☐ No (AIC will process)

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

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

ICD 10-Code: _____ (Provide full completed code) **Description:** _____

Primary Diagnosis (Check one Category)

☐ Acute Bacterial Skin and Skin Structure Infection
☐ Cellulitis
☐ Cutaneous abscess / furuncle / carbuncle
☐ MRSA or MSSA infection
☐ Gram-negative skin infection
☐ Pneumonia (when IV outpatient therapy appropriate)
☐ Other bacterial infection (specify): _____

REQUIRED DOCUMENTATION: Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results (CBC, CMP, TB, Hep B panel-depending on medication) , signed prescription order and recent visit notes.
Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

PRESCRIPTION INFORMATION

Nursing: Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

Pre-Medications

☐ Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mgPO
☐ Cetirizine (Zyrtec) 10mgPO
☐ Loratadine (Claritin) 10mgPO
☐ Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV
☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 125mg IV
☐ Other: _____ Dose: _____ Route: _____

Lab Orders

Required: Serum Creatinine / eGFR or Creatinine Clearance
☐ Other: _____

Baxdela Medication

(Select one):
Dosing: ☐ Infuse 300 mg intravenously every 12 hours over 60 minutes for _____ days
☐ Infuse 200 mg intravenously every 12 hours over 20 minutes for _____ days (for Severe Renal Impairment)

Post Treatment Observations: The patient is required to stay for 30 minutes following the first administration.

Special Instructions: _____

_____

Refills: ☐ zero ☐ for 12 months ☐ _____ *(Prescription valid for one year, unless otherwise indicated)*

PROVIDER INFORMATION

Provider Full Name: _____ Provider NPI #: _____ Specialty: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

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

_____ _____ _____
Provider Name (Print) *Provider Signature* *Date*

Greater Houston Area F: 832.510.7824 P: 832.800.3213
McAllen F: 956.302.8906 P: 832.800.3213 Plano: F: 214.831.9829 P: 972.865.4454
Harlingen F: 956.341.9687 P: 832.800.3213 Laredo F: 956.306.3715 P: 832.800.3213
Other Locations (Oaklawn, Lancaster, etc)**: F: 469.305.2361 P: 972.865.4454**

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