General Infusion Order Form

Provider Order Form *rev. 12/30/2025*

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 & Description (Primary diagnosis):

ICD 10 Code: _____ Description: _____ ☐ Other Information: _____

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
☐ Hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: _____ Dose: _____ Route: _____ Frequency: _____

Lab Orders

Lab:_____ Frequency: _____
Lab:_____ Frequency: _____
Lab:_____ Frequency: _____

Medication to Order: (Select one)

☐ Actemra ☐ Apretude ☐ Aranesp ☐ Avsola ☐ Benlysta ☐ Cabenuva ☐ Cimzia ☐ Cosentyx IV ☐ Entyvio ☐ Evenity ☐ Fasenra ☐ Feraheme
☐ Inflectra ☐ Infliximab ☐ Injectafer ☐ Kisunla ☐ Krystexxa ☐ Lemtrada ☐ Leqembi ☐ Leqvio ☐ Nucala ☐ Nulojix ☐ Ocrevus Zunovo
☐ Ocrevus ☐ Procrit ☐ Prolia ☐ Radicava ☐ Remicade ☐ Renflexis ☐ Retacrit ☐ Rituximab ☐ Rystiggo ☐ Saphnelo ☐ Simponi Aria
☐ Skyrizi IV ☐ Soliris ☐ Solu-Medrol ☐ Stelara ☐ Tepezza ☐ Tezspire ☐ Tremfya ☐ Truxima ☐ Tysabri ☐ Ultomiris ☐ Uplizna
☐ Venofer ☐ Vivitrol ☐ Vyepti ☐ Vyvgart ☐ Vyvgart Hytrulo ☐ Xolair ☐ Zoledronic Acid ☐ Other: _____

Confirm Drug: _____
Dose: _____ **Route:** _____ **Frequency:** _____ **Duration:** _____

Post Treatment Observations: The patient is required to stay for 30 minutes following the first administration.
Special Instructions: _____
(If not indicated the medication order will expire one year from date signed

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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