Nephrology Referral Form

Provider Order Form *rev. 1/12/2026*

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 (Provide full completed code)

ICD-10 Code: _____

ICD-10 Description: _____

_____

Lab Orders: _____

_____

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

☐ Other: _____ Dose: _____ Route: _____

Medication	Dose/Strength	Directions	Refill
☐ **Procrit**	☐ 2,000 units/ml ☐ 3,000 units/ml ☐ 4,000 units/ml ☐ 10,000 units/ml ☐ 20,000 units/ml MDV ☐ 20,000 units/2ml MDV ☐ 40,000 units/ml	☐ SQ Every Week ☐ SQ Twice Weekly ☐ SQ Three Times Weekly ☐ _____	_____
☐ **Aranesp**	☐ 25mcg SDV ☐ 40mcg SDV ☐ 60mcg SDV ☐ 100 mcg SDV ☐ 200mcg SDV ☐ 300 mcg SDV ☐ 10mcg/0.4ml PFS ☐ 25mcg/0.42ml PFS ☐ 40mcg/0.4ml PFS ☐ 60mcg/0.3ml PFS ☐ 100mcg/0.5ml PFS ☐ 150mcg/0.3ml PFS ☐ 200mcg/0.4ml PFS ☐ 300mcg/0.6ml PFS ☐ 500mcg/1ml PFS	☐ SQ Every Week ☐ SQ Every Other Week ☐ IV Every Week ☐ IV Every Other Week ☐ _____	_____
☐ **Retacrit**	☐ 2,000 units/ml ☐ 3,000 units/ml ☐ 4,000 units/ml ☐ 10,000 units/ml ☐ 40,000 units/ml	☐ _____	_____
☐ **Benlysta**	☐ 200 mg/ml single-dose prefilled autoinjector ☐ 200 mg/ml single-dose prefilled syringe ☐ _____	☐ SQ Every Week ☐ SQ Every Other Week ☐ IV Every Week \ ☐ IV Every Other Week ☐ _____	_____
☐ **Krystexxa**	☐ 8 mg/vial	8 mg given as an intravenous infusion every 2 weeks	_____
☐ **Other:**_____	_____	_____	_____

Special Instructions: _____

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*

E: Referrals@americaninfusioncare.com
Americaninfusioncare.com

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**