

Provider Order Form Revised 10/30/2025

**PROVIDERS: Please include the following information to expedite the order:**  
Patient Demographic, most recent Office Visit Note, Insurance Information, TB Results, Recent Labs

**PATIENT INFORMATION**

**Referral Status:**  New Referral  Updated Order  Order Renewal

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
ICD-10 code:  D80. \_\_\_\_\_  D81. \_\_\_\_\_  D82. \_\_\_\_\_  D83. \_\_\_\_\_  G61.81  Other: \_\_\_\_\_  
ICD 10 Description: \_\_\_\_\_  
 NKDA Allergies: \_\_\_\_\_ Weight (lb/kg) \_\_\_\_\_  
Patient Status:  New to Therapy  New to Therapy Last Treatment Date: \_\_\_\_\_ Next Due Date: \_\_\_\_\_

**PROVIDER INFORMATION**

Referral Coordinator Name: \_\_\_\_\_ Referral Coordinator Email: \_\_\_\_\_  
Ordering Provider: \_\_\_\_\_ Provider NPI: \_\_\_\_\_  
Referring Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**NURSING**

- Provide TB status & date (list results and attach clinicals)  
\_\_\_\_\_
- Utilize Hypersensitivity protocol established by Redeemer Health Infusion and PI
- Provide nursing care and observation per Redeemer Health Infusion Policies and Procedures

**LABORATORY ORDERS**

- CBC  at each dose  every \_\_\_\_\_
- CMP  at each dose  every \_\_\_\_\_
- CRP  at each dose  every \_\_\_\_\_
- Other: \_\_\_\_\_
- Please check this box if you do NOT authorize Redeemer Health Infusion to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

**PRE-MEDICATION ORDERS**

- acetaminophen (Tylenol)  500 mg/  650 mg/  1000 mg PO
- cetirizine (Zyrtec) 10 mg PO
- loratadine (Claritin) 10 mg PO
- diphenhydramine (Benadryl)  25 mg/  50 mg  PO/ IV
- methylprednisolone (Solu-Medrol)  40 mg/  125 mg IV
- hydrocortisone (Solu-Cortef) 100 mg IV
- Other: \_\_\_\_\_  
Dose: \_\_\_\_\_ Route: \_\_\_\_\_  
Frequency: \_\_\_\_\_

**THERAPY ADMINISTRATION**

- HyQvia 10\$ Subcutaneous Infusion
  - Dose: \_\_\_\_\_ mg/kg
  - **Route:**  Subcutaneous
  - **Rate:** Infuse SQ over 5-15 minutes according to body weight and PI recommendations.
  - **Frequency:**
    - Every 2 weeks /  Every 3 weeks /  Every 4 weeks
    - Other: \_\_\_\_\_
- Refills:  Zero/  for 12 months/  Other: \_\_\_\_\_  
(If not indicated, order will expire one year from date signed)

*To ensure a brand name product is dispensed, the prescriber must  
handwrite "Brand Medically Necessary" on the prescription form. If not  
indicated, Redeemer Infusion is authorized to administer a generic or  
biosimilar.*

**SPECIAL INSTRUCTIONS**

Please check this box if you DO NOT authorize Redeemer Health Infusion to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.

Provider Name (Print)

Provider Signature

Date