



Jupiter Infusion  
 140 Jupiter Lakes Blvd, Suite A  
 Jupiter, FL 33458  
 Office: 561-277-9211

OB/GYN Order Form

**PATIENT INFORMATION:** Fax completed form, insurance information, and clinical documentation to 561-277-9226

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

**MEDICAL INFORMATION**

Patient Weight: \_\_\_\_\_ lbs./kg. (required) Allergies: \_\_\_\_\_

**THERAPY ORDER**

Diagnosis	Infusion Orders	
<input type="checkbox"/> Mild Hyperemesis <input type="checkbox"/> Hyperemesis w/ metabolic disturbance <input type="checkbox"/> Other: _____ ICD-10: _____	<input type="checkbox"/> 1 Liter <input type="checkbox"/> 2 Liters D5 0.45 NS IV x 1 day <input type="checkbox"/> 1 Liter <input type="checkbox"/> 2 Liters NS IV x 1 day <input type="checkbox"/> 1 Liter <input type="checkbox"/> 2 Liters Ringers Lactate IV x 1 day <input type="checkbox"/> 1 Liter <input type="checkbox"/> 2 D5/Ringers Lactate x 1 day	<input type="checkbox"/> Zofran 4mg IVP x1 <input type="checkbox"/> Zofran 8mg IVP x 1 <input type="checkbox"/> May repeat regimen x _____ days
<input type="checkbox"/> Iron Deficiency Anemia <input type="checkbox"/> Other medical necessity: _____ ICD-10: _____	<b>**If the patient has Aetna, Cigna, Humana, or UHC, the patient must try and fail Venofer first**</b>  <input type="checkbox"/> Venofer 200mg IV – Administer 5 doses over a 14-day period <input type="checkbox"/> Venofer 200 mg IV weekly x 5 doses  <input type="checkbox"/> Injectafer 15mg/kg IV – Give 2 doses at least 7 days apart not to exceed 1500mg (weight <50kg) <input type="checkbox"/> Injectafer 750mg IV – Give 2 doses at least 7 days apart not to exceed 1500mg (weight >50kg)  <input type="checkbox"/> Monoferric 20mg/kg IV x 1 dose (weight <50kg) <input type="checkbox"/> Monoferric 1000mg IV x 1 dose (weight >50kg)	
<input type="checkbox"/> Pyelonephritis <input type="checkbox"/> Complicated UTI <input type="checkbox"/> Other: _____ ICD-10: _____	<input type="checkbox"/> Rocephin 1gm IV daily x 7 days <input type="checkbox"/> Rocephin 2gms IV daily x 7 days <input type="checkbox"/> Invanz 1gm IV daily x 7 days <input type="checkbox"/> Other: _____	
<input type="checkbox"/> Migraines <input type="checkbox"/> Other: _____ ICD-10: _____	<input type="checkbox"/> Zofran 4mg IVP x 1 <input type="checkbox"/> Zofran 8mg IVP x 1 <input type="checkbox"/> Reglan 10mg IV x 1 <input type="checkbox"/> May repeat regimen x _____ days	<b>**NON-OB PATIENTS ONLY**</b> <input type="checkbox"/> Magnesium Sulfate 1 gm IV x 1
<input type="checkbox"/> Other: _____ ICD-10: _____	<input type="checkbox"/> Other: _____	

Please provide patient's demographic information, insurance information, medication list, and clinical notes. Jupiter Infusion will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and assist them in enrolling in any available co-pay assistance programs as needed/applicable. Thank you for the referral.

**PROVIDER INFORMATION**

Provider Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Contact Person: \_\_\_\_\_