aleracare
advanced specialty pharmacy

Intropic
Referral Form

Patient Information			Prescriber Information	
Patient Name:		DOB:	Prescriber's Name:	
Address:			NPI#:	
City:	State:	Zip:	DEA#:	License#:
Phone:	Alternate Phone:	SSN:	Address:	
Height: Weight:		Allergies:	Phone:	Fax:
Emergency Contant:		Phone:	Contact Person:	

Client Assessment *(Please fax recent clinical notes, labs and tests to expedite the Prior Authorization Process)*

ICD-9 Codes: ______________________ **Description:** ______________________

ICD-10 Codes: ______________________ **Description:** ______________________

DATA Collection:

Results of hemodynamic monitoring:	Cardiac Index	Pulmonary capillary wedge pressure	Date
Before inotrope infusion	____________	____________	________
On inotrope infusion	____________	____________	________

Cardiac drugs provided immediately (digoxin, diuretics, vasodilators) prior to inotrope infusion (include drug, dose, and frequency):

Does this represent maximum tolerated doses of these? Yes No

Breathing status (*check one in each column*)	**Prior to inotrope infusion**	**At time of discharge**
No dyspnea on exertion		
Dyspnea on moderate exertion		
Dyspnea on mild exertion		
Dyspnea at rest		

If continuous infusion is prescribed, have attempts to discontinue inotrope infusion in the hospital failed? **Yes** **No**

Additional information: ______________________

If intermittent infusion is prescribed, have there been repeated hospitalizations for heart failure during which parenteral inotropes were required?

Yes **No** Additional information: ______________________

Is the patient capable of going to the physician for outpatient evaluation? **Yes** **No**

Is routine electrocardiographic monitoring required in the home? **Yes** **No**

Has the patient been stabilized on the prescribed inotrope dose for 24 hours? **Yes** **No**

alerácare
advanced specialty pharmacy

Intropic
Referral Form

Patient Name:

Medication Orders

The maintenance dose will be established and patient stabilized on maintenance dose before first home infusion. Titration of the maintenance dose should not be done in home setting. Safe doses of the drugs should fall within ranges noted below. Any doses falling outside of these ranges should be double checked with a MedicoRX Specialty Pharmacist.

Dobutamine: 2.5-10 mcg/kg/min

Milrinone: 0.375-0.75 mcg/kg/min

Ordered Medication: ______________________________ Dose __________ mcg/kg/min

Clinical rational for the prescription outside the above dosing ranges ____________________ or N/A ____________

____ or N/A ____________

Dosing weight: __________ kg

Continuous ________ Intermittent ________ Frequency ____________ Duration: ____________

Pharmacy to dispense 1 pump plus 1 spare pump for emergency.

Dose adjustment: Pharmacy to contact the prescriber every ________ week(s).

Dosing will be adjusted under the direction of a physician based upon the patient's response.

IV access (check one) PICC __________ Midline __________ Other __________ # of lumens __________

Lab: CBC ________ CMP ________ Other ________ Lab frequency: Weekly __________ Other ________

Flushorders/Instruction:____

(Do not use Heparin flush with Dobutamine: Incompatible)

By signing this form I authorize AleraCare and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

Prescriber's Signature **Date**