Inotropic

REFERRAL FORM

Phone: 818-390-9696 Toll-free: 855-265-7850 ● Fax: 818-804-3492 ● Toll-free fax: 855-450-6717 ● info@MedicoRX.com

Patient information		Prescriber information	
Name:	**DOB:**	**Prescriber's Name:**	
Address: **City, State, Zip**		**NPI#**	
		DEA#	**License#**
Phone #	**Alt#**	**Address** **City, State, Zip**	
SSN:			
Height:	**Wt:**	**Phone #**	**Fax #**
Allergies:			
Emergency Contact/ Phone #		**Contact Person:**	

Clinical 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

Patient's 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 _____

Flush orders/Instruction:_____
(Do not use Heparin flush with Dobutamine: Incompatible)

By signing this form I authorize MedicoRX 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 (no stamps) if brand required check this ☐ DAW___ **Date**