MISSION VALLEY MEDICAL INFUSION CENTER

3530 Camino Del Rio N #200, San Diego, CA 92108 | Phone (619) 230-5123 | info@missionvalleyiv.com

FAX COMPLETED REFERRALS TO
(619) 228-9877

PATIENT REFERRAL & INFUSION ORDERS

HOW TO USE THIS FORM

1. Each step is tagged **OFFICE STAFF** or **PROVIDER** - fill in your parts, then hand the form off.
2. Attach the records you check in Step 8. 3. Add page 4 only for Spravato referrals. 4. The provider signs Step 11 - unsigned forms cannot be processed.

FAX TO (619) 228-9877 or send by secure email to info@missionvalleyiv.com.

* marks the minimum we need to start authorization - send what you have and we will call your office for the rest.

STEP 1 — WHAT ARE YOU SENDING? OFFICE STAFF

Choose one in each row

☐ New referral ☐ Renewal of an existing order ☐ Change to an existing order

☐ Routine - we contact the patient within 2 business days ☐ Urgent - we contact the patient same day

REQUESTED START DATE (MM/DD/YYYY)

IF RENEWAL OR CHANGE, WHAT IS DIFFERENT?

STEP 2 — PATIENT OFFICE STAFF

***** LAST NAME | ***** FIRST NAME | ***** DATE OF BIRTH (MM/DD/YYYY) | SEX (M/F/X) | HEIGHT (IN) | ***** WEIGHT (LBS/KG) | DATE WEIGHED

***** PRIMARY PHONE NUMBER | SECOND PHONE | EMAIL

STREET ADDRESS | APT / SUITE / UNIT | CITY | STATE | ZIP

EMERGENCY CONTACT NAME | RELATIONSHIP TO PATIENT | EMERGENCY CONTACT PHONE | CAREGIVER OR LEGAL REPRESENTATIVE, AND PHONE | PRIMARY LANGUAGE

PRIMARY CARE PROVIDER | PCP FAX OR SECURE EMAIL

***** ANY DRUG OR FOOD ALLERGIES?

☐ Yes ☐ No ☐ NKDA (no known drug allergies)

***** IF YES, LIST ALL ALLERGIES AND REACTIONS

Patient authorized us to discuss care with the caregiver above?	☐ Yes	☐ No	May we send visit notes to the PCP above?	☐ Yes	☐ No
OK to send the patient text messages?	☐ Yes	☐ No	OK to leave a detailed voicemail?	☐ Yes	☐ No
Interpreter needed? (provided at no cost to the patient)	☐ Yes	☐ No	Needs transport help or has mobility limits?	☐ Yes	☐ No

STEP 3 — INSURANCE OFFICE STAFF

Attach a copy of the card(s), front and back - see Step 8

***** PRIMARY INSURANCE | ***** MEMBER ID | GROUP # | SECONDARY INSURANCE | MEMBER ID

STEP 4 — DIAGNOSIS OFFICE STAFF OR PROVIDER

***** PRIMARY ICD-10 CODE | ***** DIAGNOSIS | SECOND ICD-10 CODE | DIAGNOSIS

BRIEF HISTORY, SEVERITY, AND ANY THERAPIES ALREADY TRIED AND FAILED

STEP 5 — THERAPY REQUESTED PROVIDER

Listed alphabetically

☐ Biologic or Biosimilar infusion + ☐ Electrolyte infusion ☐ GLP-1 / Zepbound weight management +

☐ Glutathione ☐ Iron infusion (Venofer) ☐ IV hydration

☐ Ketamine IV/IM - mental health ☐ Ketamine IV/IM - pain management ☐ NAD+ therapy

☐ OPAT / IV antibiotic or antifungal + ☐ Spravato / esketamine - also complete page 4 ☐ Vitamin infusion

\+ New service line now launching - we will confirm availability and timing when we contact your office.

***** IF BIOLOGIC OR BIOSIMILAR IS CHECKED, BRAND/GENERIC NAME | OTHER THERAPY NOT LISTED ABOVE

Ketamine or Spravato only - confirm with the patient: is a driver or escort arranged? (the patient may not drive home after treatment) ☐ Yes ☐ No

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***** PATIENT NAME

***** DATE OF BIRTH

STEP 6 — ORDERS PROVIDER

Or write "per MVMIC protocol"

***** MEDICATION(S) | ***** DOSE | ***** ROUTE | DILUENT AND VOLUME | INFUSE OVER / RATE

***** HOW OFTEN | HOW MANY TREATMENTS | ORDERS GOOD THROUGH (12 MONTHS MAXIMUM) | PREMEDICATION, TITRATION OR RATE INSTRUCTIONS

LABS NEEDED BEFORE OR DURING THERAPY | IV ACCESS (PIV, PORT, PICC, MIDLINE) | POST-INFUSION OBSERVATION

☐ Dispense as written / brand necessary ☐ Substitution permitted ☐ MVMIC may manage rate and treat reactions per protocol

STEP 7 — SAFETY QUESTIONS PROVIDER

Mark Yes or No for every line

Any past reaction to an infusion or IV contrast?	☐ Yes	☐ No	On a blood thinner or antiplatelet?	☐ Yes	☐ No
Active or recent infection?	☐ Yes	☐ No	Pregnant or breastfeeding?	☐ Yes	☐ No
Kidney impairment (eGFR under 60)?	☐ Yes	☐ No	Liver impairment?	☐ Yes	☐ No
Heart disease or uncontrolled high blood pressure?	☐ Yes	☐ No	Immunosuppressed?	☐ Yes	☐ No
History of blood clots or clotting disorder?	☐ Yes	☐ No	Known difficult IV access?	☐ Yes	☐ No
Fall risk or needs assistance?	☐ Yes	☐ No	Unstable psychiatric illness?	☐ Yes	☐ No

EXPLAIN ANYTHING YOU MARKED YES

STEP 8 — RECORDS TO ATTACH OFFICE STAFF

Missing records cause most delays

☐ Insurance card, front and back ☐ History & physical, past 12 months ☐ Current medication list

☐ Recent labs (CBC, CMP, drug-specific) ☐ Therapies tried and failed ☐ Imaging or pathology reports

☐ Prior infusion records ☐ TB screening / vaccinations ☐ Signed prescription or order

☐ Other - describe below

IF YOU CHECKED OTHER, DESCRIBE WHAT YOU ARE SENDING

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***** PATIENT NAME

***** DATE OF BIRTH

STEP 9 — ANYTHING ELSE WE SHOULD KNOW — OFFICE STAFF OR PROVIDER

Special requests, patient concerns

STEP 10 — REFERRING PROVIDER — PROVIDER

Requires a current U.S. state license

PROVIDER TYPE - CHECK ONE

☐ MD ☐ DO ☐ PA ☐ NP

***** STATE LICENSE NUMBER | ***** LICENSE STATE | ***** IF PA OR NP - SUPERVISING / COLLABORATING PHYSICIAN AND NPI

☐ NP practicing under California 103 / 104 independent practice authority - no supervising physician required

***** PROVIDER NAME AND CREDENTIALS | ***** NPI | DEA (CONTROLLED SUBSTANCES ONLY) | SPECIALTY

PRACTICE NAME | ***** OFFICE PHONE | ***** OFFICE FAX

SECURE EMAIL | FORM COMPLETED BY (NAME AND TITLE) | DIRECT PHONE OR EXTENSION FOR QUESTIONS

HOW SHOULD WE SEND YOU UPDATES AND INFUSION NOTES?

☐ Secure email ☐ Fax ☐ Phone ☐ EHR / direct message

STEP 11 — SIGN HERE — PROVIDER

Unsigned referrals cannot be processed

I hold a current, unrestricted license as an MD, DO, PA or NP in a U.S. state, and this referral is within my scope of practice. I am the treating provider, this therapy is medically necessary for the diagnosis above, and the information here is accurate to the best of my knowledge. I authorize MVMIC to verify benefits, obtain prior authorization, and coordinate care with the patient, the payer and my office. I remain the prescriber of record and will respond to clinical questions arising during therapy.

A typed name is not a signature. Sign by hand or apply a digital signature. No stamp signatures.

***** PRESCRIBER SIGNATURE | ***** PRINTED NAME | ***** DATE | ***** TIME

BEFORE YOU FAX — OFFICE STAFF

A 20-second check that prevents most delays

- ☐ Every Yes/No line is marked - none left blank
- ☐ Patient has NO insurance / self-pay - no card needed
- ☐ Medication, dose, route and frequency filled in
- ☐ If PA or NP, supervising physician listed
- ☐ Page 4 attached if referring for Spravato
- ☐ Insurance card copy attached, front and back
- ☐ History & physical and medication list attached
- ☐ Allergies answered - Yes with list, or NKDA
- ☐ Provider signed and dated
- ☐ All 4 pages included, patient name on each

MVMIC INTERNAL USE ONLY

DATE & TIME REFERRAL RECEIVED | RECEIVED BY (INITIALS) | PATIENT RECORD NUMBER (MRN) | INSURANCE & PRIOR AUTH VERIFIED - DATE & INITIALS

PROVIDER LICENSE CHECKED - DATE & INITIALS | ORDERS ACCEPTED BY RN - DATE & INITIALS | APPROPRIATE FOR OUTPATIENT INFUSION? Y/N + INITIALS | FIRST TREATMENT DATE

SEND THIS FORM: FAX (619) 228-9877 • Secure email info@missionvalleyiv.com • Questions (619) 230-5123

We contact your patient within one business day of a complete referral and send your office confirmation of scheduling plus the first infusion note.

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SPRAVATO (ESKETAMINE) SUPPLEMENT

MVMIC is a REMS-certified healthcare setting. Under the SPRAVATO REMS, three enrollments must be active before the first dose: the setting (MVMIC), the prescriber, and the patient. Every dose is given on site with at least 2 hours of monitoring, pulse oximetry and blood pressure checks, and Spravato is never dispensed for home use.

Send this page with pages 1 through 3. Our REMS coordinator will call your office to complete prescriber and patient enrollment.

A — PATIENT AND PRESCRIBER

***** PATIENT NAME | ***** DATE OF BIRTH | ***** PRESCRIBER NAME | ***** NPI | DATE

B — INDICATION, DOSE AND SCHEDULE

Choose one indication and one starting dose

☐ Treatment-resistant depression (with an oral antidepressant)
☐ Depressive symptoms in MDD with acute suicidal ideation or behavior

☐ Starting dose 56 mg
☐ Starting dose 84 mg
☐ New start (induction)
☐ Continuing therapy / transfer of care

IF CONTINUING, DATE AND DOSE OF LAST TREATMENT

REQUESTED SCHEDULE (TRD DEFAULT: TWICE WEEKLY WEEKS 1-4, WEEKLY WEEKS 5-8, THEN EVERY 1-2 WEEKS)

C — ORAL ANTIDEPRESSANT AND PRIOR TRIALS

TRD requires an adequate trial of at least two antidepressants in the current episode

***** CURRENT ORAL ANTIDEPRESSANT | ***** DOSE | STARTED (DATE) | MOST RECENT DEPRESSION SCORE (PHQ-9, MADRS) AND DATE

ANTIDEPRESSANT TRIED	DOSE	DATES	OUTCOME OR REASON STOPPED

D — SAFETY SCREEN

The first three are contraindications to Spravato

Aneurysmal vascular disease (any site)?	☐ Yes	☐ No	Arteriovenous malformation?	☐ Yes	☐ No
History of intracerebral hemorrhage?	☐ Yes	☐ No	Hypersensitivity to esketamine or ketamine?	☐ Yes	☐ No
Uncontrolled or unstable hypertension?	☐ Yes	☐ No	Pregnant, breastfeeding, or planning pregnancy?	☐ Yes	☐ No
Moderate or severe hepatic impairment?	☐ Yes	☐ No	History of psychosis or mania?	☐ Yes	☐ No
Sleep apnea or other respiratory compromise?	☐ Yes	☐ No	Current substance use disorder?	☐ Yes	☐ No

EXPLAIN ANYTHING MARKED YES

E — REMS AND COUNSELING ACKNOWLEDGEMENTS

Check each item you can confirm

☐ I am enrolled, or will enroll, as a prescriber in the SPRAVATO REMS
☐ I will complete the REMS patient enrollment form with this patient, or authorize MVMIC to coordinate it
☐ Patient counseled on sedation, dissociation, respiratory depression and blood pressure changes
☐ Patient understands at least 2 hours of on-site monitoring after every dose, and has transport arranged
☐ Patient understands no driving or hazardous activity for the rest of the day, until after restful sleep
☐ Patient advised: no food 2 hours before and no liquids 30 minutes before each dose

F — PRESCRIBER SIGNATURE

Required in addition to the signature on page 3

I hold a current, unrestricted U.S. state license as an MD, DO, PA or NP. I remain the prescriber of record for this patient. I understand that MVMIC will administer Spravato on site, monitor the patient for at least 2 hours with pulse oximetry and blood pressure checks, and submit the REMS Patient Monitoring Form. A typed name is not a signature. No stamp signatures.

***** PRESCRIBER SIGNATURE | ***** PRINTED NAME | ***** DATE | ***** TIME