



# B-12 Order Form

Select patient referral location: Anchorage Palmer Fairbanks

Please fax or securely email to 1-907-921-7669 or RX@luxinfusion.com.  
For new referrals, please **include recent labs and last two office visit notes.**  
Clinic Phone Number: 1-907-744-1944 · luxinfusion.com

1. PATIENT INFORMATION	
Name:	DOB:
Home phone:	Other phone:
Email:	
Social Security #:	Allergies:
Gender: M F	Weight:
Patient Status: New to therapy Continuing therapy	Next due date (if applicable):

2. PHYSICIAN INFORMATION	
Physician's Name:	NPI#:
License #: TIN#:	DEA#:
Address:	
City:	State: Zip:
Office contact:	Email:
Office phone:	Office fax:

3. DIAGNOSIS INFORMATION (and year of diagnosis)	
Addisonian anemia ICD 10 ( ) B-12 Deficiency ( )	Other (specify):

4. INSURANCE INFORMATION	
Please submit copies of the front and back or primary and secondary insurance cards with this referral.	

5. PRESCRIPTION INFORMATION (requires new order every 12 months)	
<b>B-12</b>	<b>PRE-MEDICATIONS</b> N/A
Administer ____ mg SubQ every ____ week(s) for ____ week(s)	Acetaminophen 500mg 650mg 1000mg PO Cetirizine (Zyrtec) 10mg PO (or other non-sedating anti-histamine) Diphenhydramine (Benadryl) 25mg 50mg PO IV (requires driver) Methylprednisolone (Solu-Medrol) 40mg 80mg 125mg IV Prednisone _____ mg PO Other: _____
Vital signs per LUX Protocol Anaphylaxis & Hydration Management per LUX Protocol	<b>POST-MEDICATIONS</b> N/A Acetaminophen 500mg 650mg 1000mg PO Prednisone _____ mg PO Other: _____

## 6. SIGNATURE (required)

PHYSICIAN'S SIGNATURE DATE