

IV Ketamine Order Form

Pre-filled order form for IV Ketamine (ketamine infusion) — Rapid-acting infusion therapy for treatment-resistant mood conditions

REFERRING PROVIDER

PROVIDER NAME	NPI	DEA (IF CONTROLLED)	SPECIALTY
PRACTICE / CLINIC NAME		OFFICE PHONE	OFFICE FAX
OFFICE CONTACT NAME	CONTACT PHONE	CONTACT EMAIL	

PATIENT INFORMATION

PATIENT LAST NAME	FIRST NAME	MIDDLE INITIAL
DATE OF BIRTH	SEX	PATIENT PHONE
		BEST TIME TO CONTACT
ADDRESS		CITY, STATE, ZIP

INSURANCE

PRIMARY INSURANCE	MEMBER ID	GROUP #
SECONDARY INSURANCE (IF ANY)	MEMBER ID	GROUP #

DIAGNOSIS & CLINICAL JUSTIFICATION

PRIMARY DIAGNOSIS	ICD-10 CODE
SECONDARY DIAGNOSIS (IF APPLICABLE)	ICD-10 CODE

Common indications for this medication: *Treatment-resistant depression, Bipolar depression (with appropriate co-management), Post-traumatic stress disorder (PTSD), Severe anxiety in select cases, Certain chronic pain syndromes (CRPS, neuropathic pain)*

BRIEF CLINICAL SUMMARY / JUSTIFICATION FOR THERAPY

PRIOR THERAPIES TRIED AND OUTCOME

IV KETAMINE REFERENCE

Generic name: ketamine infusion
Specialty: Psychiatry & Behavioral Health
Typical infusion time: About 90 minutes (40-minute infusion + observation)
Typical schedule: Typical induction: 6 infusions over 2–3 weeks; maintenance varies

MEDICATION ORDER

MEDICATION (DEFAULT: IV KETAMINE)	GENERIC / ALT (KETAMINE INFUSION)	STRENGTH / FORMULATION
	FREQUENCY (TYPICAL: TYPICAL INDUCTION: 6 INFUSIONS OVER 2&NDASH;3 WEEKS; MAINTENANCE VARIES)	DURATION (TYPICAL: ABOUT 90 MINUTES (40-MINUTE INFUSION + OBSERVATION))
DOSE		

ROUTE	PRE-MEDICATIONS (IF ANY)	SPECIAL INSTRUCTIONS
ANTICIPATED START DATE	# OF DOSES AUTHORIZED	SUBSTITUTION ALLOWED (Y/N)
		BIOSIMILAR ACCEPTABLE (Y/N)

REQUIRED LABS & MONITORING

Check all labs the prescriber requires Ascribe to verify before each infusion:

- | | | |
|--|--|---|
| ☐ CBC w/ differential | ☐ CMP | ☐ Liver function panel |
| ☐ Hepatitis B/C panel | ☐ TB screen (T-SPOT or QFT) | ☐ Pregnancy test (urine) |
| ☐ Iron studies (ferritin, TSAT) | ☐ Vitamin levels (B12, D, folate) | ☐ Other (specify below) |

OTHER LABS / MONITORING REQUIREMENTS

PRESCRIBER SIGNATURE

By signing below I certify that this order is medically necessary, that I am the prescribing provider for this patient, and that I have reviewed the patient's clinical history relevant to this therapy. Ascribe Infusion Therapy is authorized to coordinate scheduling, prior authorization, and benefits verification on the patient's behalf.

PRESCRIBER SIGNATURE
PRINTED NAME
DATE

Form code: ARB-ORDER-KETAMINE-IV · Submit to Ascribe Infusion Therapy by fax to [FAX NUMBER] or via secure portal. Ascribe Infusion will confirm receipt within one business day and begin prior authorization the same day. Questions: [PHONE] · hello@ascribeinfusion.com