

Referral Submission Form

Please send completed form, along with patient's insurance card (front/back), and relevant clinical notes to: **support@infusionexpress.com** or fax: **(844) 293-0979**

PATIENT INFORMATION

1

Patient Name _____ DOB _____
 Address _____ Email _____
 City, State, Zip _____ Primary Phone _____
 Enrolled in Funded Program? Yes No N/A Alternate Phone _____

PRESCRIBER INFORMATION

2

Prescriber's Name _____ Practice Group _____
 State License # _____ Address _____
 DEA # _____ City, State, Zip _____
 NPI # _____ Phone # _____
 Contact Name _____ Fax # _____

INSURANCE INFORMATION (OR fax/email a copy of patient's insurance card if available)

3

Primary Payer _____ Group # _____
 Subscriber Name _____ Effective Date _____
 ID # _____ Plan Type _____
 Office Visit Copay \$ _____
Secondary Payer _____ Group # _____
 Subscriber Name _____ Effective Date _____
 ID # _____ Plan Type _____
 Office Visit Copay \$ _____

DIAGNOSIS AND CLINICAL INFORMATION

4

ICD Code _____ Hypersensitivity Treatment:
 Description _____ - IVX Policy and Procedure for Reaction ____
 Continuation Therapy? Yes No - Other _____
 If Yes, PA # ? _____ Failed Prior Treatments? Yes No
 Allergies _____ If Yes, Drugs _____
 TB/PPD Status _____ Date _____

PRESCRIPTION INFORMATION

5

Medication _____ Quantity _____
 Dose/Strength _____ Refills _____
 Induction? Yes No Premeds w/ dose _____
 Directions _____

LABS (If you would like us to draw labs for this patient, please indicate below)

6

Panel: CBC with Dif & Platelets _____ Frequency: W/ Each Dose _____
 CMP _____ Every 8-12 Weeks _____
 CRP _____ Every 6 Months _____
 SED Rate _____ Other _____
 Other _____

PHYSICIAN SIGNATURE REQUIRED

7

Patient is interested in patient support programs

X _____

DISPENSE AS WRITTEN

DATE