IVX INFUSION® EXPRESS

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) 820-9641**

1 PATIENT INFORMATION

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

2 PRESCRIBER INFORMATION

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

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

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 $ _____

4 DIAGNOSIS AND CLINICAL INFORMATION

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 _____

5 PRESCRIPTION INFORMATION

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

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

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

7 PHYSICIAN SIGNATURE REQUIRED

[ ] Patient is interested in patient support programs

X _____ _____
DISPENSE AS WRITTEN DATE

70 E Swedesford Rd Suite 130, Malvern, PA 19355
Fax: (844) 820-9641
Phone: (484) 318-2268
Email: support@infusionexpress.com