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) 900-1292**

1

PATIENT INFORMATION

Patient Name ________________________________
Address _____________________________________
City, State, Zip ______________________________
Enrolled in Funded Program? Yes No N/A

DOB ____
Email ____
Primary Phone _______________________________
Alternate Phone ______________________________

2

PRESCRIBER INFORMATION

Prescriber's Name ____________________________
State License # ______________________________
DEA # _______________________________________
NPI # ____
Contact Name ________________________________

Practice Group _______________________________
Address _____________________________________
City, State, Zip ______________________________
Phone # _____________________________________
Fax # _______________________________________

3

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

Primary Payer _____________________________
Subscriber Name _____________________________
ID # ____
Office Visit Copay $ ___________________________

Group # _____________________________________
Effective Date ________________________________
Plan Type ___________________________________

Secondary Payer ___________________________
Subscriber Name _____________________________
ID # ____
Office Visit Copay $ ___________________________

Group # _____________________________________
Effective Date ________________________________
Plan Type ___________________________________

4

DIAGNOSIS AND CLINICAL INFORMATION

ICD Code____________________________________
Description __________________________________
Continuation Therapy? Yes No
If Yes, PA # ? _______________________________
Allergies ____________________________________
____

Hypersensitivity Treatment:
- IVX Policy and Procedure for Reaction ____
- Other ____________________________________

Failed Prior Treatments? Yes No
If Yes, Drugs _________________________________
TB/PPD Status ______________ Date ___________

5

PRESCRIPTION INFORMATION

Medication __________________________________
Dose/Strength ________________________________
Induction? Yes No
Directions ___________________________________
____

Quantity ____________________________________
Refills ______________________________________
Premeds w/ dose _____________________________
____
____

6

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

Panel: CBC with Dif & Platelets ____
CMP ____
CRP ____
SED Rate ____
Other ______________________________

Frequency: W/ Each Dose ____
Every 8-12 Weeks ____
Every 6 Months ____
Other ______________________________

7

PHYSICIAN SIGNATURE REQUIRED

[ ] Patient is interested in patient support programs

X ______________________________________
DISPENSE AS WRITTEN

____
DATE

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3600 NE Ralph Powell Rd Suite B, Lee's Summit, MO 64064

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