Referral Submission Form

Please fax the completed form along with patient's insurance card and relevant clinical notes to (312) 253-7244.

Designated Infusion Express center? ____ Glenview ____ Schaumburg ____ TBD

Patient Information

Patient Name _____ DOB _____

Address _____ Email _____

City, State, Zip Code _____ Home Phone _____

Enrolled in Funded Program? ____ Yes ____ No ____ N/A Mobile Phone _____

Prescriber Information

Prescriber's Name _____ Practice Group _____

State License # _____ Address _____

NPI #_____ City, State, Zip Code _____

Contact Name _____ Phone _____

Contact Email _____ Fax _____

Insurance Information (Please fax/email insurance card if available)

Primary Payer _____ Group # _____

Subscriber Name _____ ID # _____

Secondary Payer _____ Group # _____

Subscriber Name _____ ID # _____

Diagnosis and Clinical Information

ICD Code _____ Hypersensitivity Treatment:

Description _____ ____ IVX Reaction Policy & Procedure ____ Other (If other, attach with fax)

Continuation Therapy? ____ Yes ____ No Failed Prior Treatments? ____ Yes ____ No

If Yes, PA #? _____ If Yes, Drugs _____

Allergies _____ TB/PPD Status _____ Date _____

Prescription Information

Medication _____ Quantity _____ Route of Administration: ____ IV ____ Injection

Dose/Strength _____ Length/Date Range _____

Induction? ____ Yes ____ No Premeds with Dose _____

Directions _____ _____

_____ _____

Labs (If you would like labs drawn for this patient, indicate below)

Panel: ____ CBC with Diff ____ CBC w/out Diff ____ CMP ____ Hepatic function ____ CRP ____ SED Rate ____ Other _____

Frequency: ____ With Each Dose ____ Every 8-12 Weeks ____ Every 6 Weeks ____ Other _____

Physician Signature Required

x_____ _____ | Patient is interested in patient support programs

Dispense as Written Date

GLENVIEW | 2601 Compass Rd, Ste 140 | Glenview, IL 60026 | phone: (847) 503-0007 | fax: (312) 253-7244

SCHAUMBURG | 1033 E Woodfield Rd | Schaumburg, IL 60173 | phone: (224) 803-2292 | fax: (312) 253-7244