Cardiology
Patient Referral Form

Infusion Specialist
c:
e:

PATIENT INFORMATION

Date:	Patient Name:		Last 4 SSN	DOB:
Address:		City:	ST:	Zip:
Primary Phone:			Work Phone:	
Gender: ☐M ☐F	Weight lbs/kg:	Height:	Allergies:	
Primary Insurance:			**Secondary Insurance:**	
Member#:	**Group#:**		**Member#:**	**Group#:**

Diagnosis: _____

Documentation needed: ☑ Insurance cards ☑ Most recent clinical including H&P ☑ Labs ☑ Diagnostic testing results

Medication	Order
Leqvio - Subcutaneous	☐ Initial: 284 mg day 1 and at 3 months, then maintenance ☐ Maintenance: 284 mg every 6 months
Repatha - Subcutaneous	☐ 140 mg every 2 weeks ☐ 420 mg monthly ☐ Other:

Nursing

☑ Establish and/or maintain access device as needed for dose administration
☑ Administer by ordered route
☑ Obtain vital signs prior to, throughout as directed and at completion of infusion
☑ If reaction occurs follow procedure reaction management

PROVIDER INFORMATION

By signing I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment. Axiva Health Solutions, Inc., has my permission to contact the patient's health plan to obtain authorizations necessary to enable it to receive payment for services.

Physician Name:		NPI:	DEA:	License:
Address:		City:	ST:	Zip:
Phone:	Fax:		Office Contact:	

_____ _____ ♦ _____ _____
Physician Signature Required – Substitution Permitted Date Physician Signature Required – Dispense as Written Date

FAX completed form to Axiva 844.440.0101 **Intake Specialist: 844.44-AXIVA (844.442.9482)**