axiva

Patient Referral Form

PATIENT INFORMATION

Date: Patient Name: Last 4 SSN DOB:

Address: City: ST: Zip:

Primary Phone: Work Phone:

Gender: ☐M ☐F Weight lbs/kg: ICD-10 code: ICD-10 Description:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy (If yes, did patient have reaction with 1st dose? ☐ Y ☐ N)

☐ Next Due Date (if applicable):_____

Primary Insurance: **Secondary Insurance:**

Member#: **Group#:** **Member#:** **Group#:**

ATTACH DOCUMENTS TO FAX

☑ Copy of insurance card(s) ☑ Labs

☑ Patient demographics ☑ H&P (clinical) Other: _____

Clinical Information

Drug:

Orders: ☐Will Send ☐Attached ☐Below

Infusion Location:

☐ No Preference ☐ Havertown Ambulatory Infusion Suite

☐ Home ☐ Huntingdon Valley Ambulatory Infusion Suite

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 **Patient Navigator 844.44-AXIVA (844.442.9482)**