ivira specialty pharmacy

General Referral Form

Please fax completed referral form to ivira:
(302) 499-8729
Please contact office for questions:
(302) 499-8727

PATIENT DEMOGRAPHICS:

PATIENT NAME:	PREFERRED CONTACT #:
DATE OF REFERRAL:	SECONDARY CONTACT #:
SOCIAL SECURITY NUMBER:	ADDRESS:
DATE OF BIRTH: GENDER: ☐ F ☐ M	CITY, STATE, ZIP:

PRIMARY DIAGNOSIS: PLEASE PROVIDE ICD-IO CODE

☐ _____ - _____

PATIENT INFORMATION:

ALLERGIES: ☐ NKDA	FIRST DOSE: ☐ Y ☐ N
	DATE OF LAST DOSE:
	NEXT DOSE DUE BY:

REQUIRED DOCUMENTATION: PLEASE PROVIDE A COPY OF THE FOLLOWING DOCUMENTS

☐ 1. INSURANCE CARD (Front & Back) ☐ 2. MOST RECENT LABS ☐ 3. PATIENT DEMOGRAPHICS ☐ 4. H&P

INSURANCE INFORMATION:

PRIMARY INSURANCE RX ID#

RX GROUP#	RX BIN# (*6 digits*)	RX PCN# (*if available*)

SECONDARY RX ID#

RX GROUP#	RX BIN# (*6 digits*)	RX PCN# (*if available*)

MEDICATION SELECTION:

Rx

DRUG:

SIG:

REFILLS: 1 2 3 4 5 6 1yr OTHER: _____ QTY TO DISPENSE: _____ SHIP TO: ☐ HOME ☐ OFFICE

PRESCRIBER INFORMATION:

PHYSICIAN NAME:	PHONE:
OFFICE CONTACT:	FAX:
ADDRESS:	LICENSE #:
CITY, STATE, ZIP:	NPI:

PHYSICIAN SIGNATURE: DATE: