

Referral for Injectable Medication



Phone: 877.385.0535
Fax: 877.326.2856

Please complete each section of the referral form below and fax to OptiMed along with a copy (front and back) of all the patient's pharmacy and medical insurance cards, the patient's demographic face sheet, and any relevant clinical notes/documents.

Prescriber Information	<p>Prescriber: _____ NPI: _____</p> <p>Phone: _____ Fax: _____ Office Contact: _____</p> <p>Address: _____</p>
Patient Information	<p>Name: _____ DOB: _____ <input type="checkbox"/> M <input type="checkbox"/> F</p> <p>Address: _____</p> <p>Phone: _____ 2nd Phone: _____ SSN: _____</p> <p>Primary Language: _____ Functional Limitations: _____</p>
Clinical Information	<p>Diagnosis (Include ICD-10 Code): _____</p> <p>Serum Calcium (for Osteoporosis patients only): _____ Date: _____</p> <p>Weight: _____ <input type="checkbox"/> lb <input type="checkbox"/> kg Height: _____ <input type="checkbox"/> in</p> <p>Allergies: _____ Latex allergy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Prior treatments & reason for discontinuation: _____</p> <p>Significant medical history: _____</p> <p>Will this be the patient's first dose? <input type="checkbox"/> Yes <input type="checkbox"/> No, date of last dose: _____ Response to prior doses: _____</p> <p>Additional notes: _____</p>
Prescription Information	<p>Medication: _____ Dose: _____ Route of administration: _____</p> <p>Frequency: _____ Quantity (# of doses): _____</p> <p>Nursing and Supplies: OptiMed to provide supply items and nursing care to prepare and administer product as per package instructions.</p> <p>Additional instructions: _____</p> <p>Lab orders: List any outpatient laboratory work related to this therapy you would like OptiMed to draw in conjunction with the patient's medication administration, including the frequency for each lab order. Lab orders are good for the life of the prescription order (one year) unless otherwise indicated. (Lab orders are subject to availability)</p>
Prescriber Signature	<p>My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize OptiMed and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide administrative nursing services and supplies in conjunction with the therapy prescribed above.</p> <p>Signature: _____ Date: _____</p>

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