



844-243-7833 Phone
 844-893-7279 Fax
 QUESTIONS? Please contact us!
 Info@ClinIVoy.com

Patient Referral Form

Send your referral to:

Date Medication Needed: _____

1. Patient Information | Insurance Information Please include copies of the FRONT and BACK of ALL insurance cards (prescription and medical) with this fax.

Patient Name: _____ Birthdate: _____ Sex: () Male () Female Height: _____ Weight: _____ () lbs. () kg.
 Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Alternate Caregiver Name: _____ Preferred Phone: _____

2. Referring Physician Information

Referral Name: _____ Specialty: _____ NPI Number : _____
 Address: _____ Phone: _____ Fax: _____
 City, State, Zip: _____ Key Contact: _____ Phone: _____

3. Diagnosis/Clinical Information Please include recent clinical notes, labs, tests, with the prescription to expedite the prior authorization.

Body Weight: _____ lb/Kg Age: _____ Adult/Pediatric: _____

Diagnosis:

- ICD-10
- ICD-10
- ICD-10
- ICD-10

Lab Work:

- _____ _____
- _____ _____
- _____ _____

History / Current Medical Status:

Tried and Failed Medication:

4. Prescription Information

Drug Name	Strength	Dose / Frequency / Route	Refill

5. Referring Physician Signature

Prescriber, Please sign and date below

Referring Signature

Substitution Permissible

Date

6. Patient Support Programs

Please sign and date below to enroll in the pharmaceutical company assisted patient support program.

Patient Signature

Date

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. In no event should such material be read or retained by anyone other than the named addressee, except by express authorization of the sender to the named addressee. Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.