DR. IKE'S PHARMACY
ADVANCED SPECIALTY PHARMACY

INFUSION THERAPY
REFERRAL FORM

Fax: **888.804.7717**

Ship To: ❑ Patient ❑ Physician/Clinic Date Shipment Needed: _____ **Rx**: ❑ New ❑ Refill _____

PATIENT INFORMATION

Patient's Full Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alt. Phone: _____
Patient SS#: _____
DOB: _____
Allergies: _____
Gender: ❑ Male ❑ Female

Diagnosis: _____ ICD9 Code: _____
Patient's Weight: _____ Height: _____

Primary Insurance: _____
ID#: _____ Phone: _____
Secondary Insurance: _____
ID#: _____ Phone: _____

PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

IV MEDICATION		DIRECTIONS (Frequency of Administration)
❑ Ancef (Cefazolin)	❑ Solu-Medrol (Methylprednisolone)	
❑ Cubicin (Daptomycin)	❑ Unasyn (Ampicillin-sulbactam)	
❑ Invanz (Ertapenem)	❑ Vancomycin (Vancocin)	
❑ Levaquin (Levofloxacin)	❑ Zosyn (Piperacillin)	
❑ Maxipime (Cefepime)	❑ IVIG (Immune Globulin)	
❑ Primaxin (Imipenem)	❑ TPN (Parental Nutrition)	
❑ Rocephin (Ceftriaxone)	❑ Other:	

NURSING	1st DOSE	LINE ACCESS
❑ TNH NURSING	❑	❑ PICC ❑ PERIPHERAL
❑ AGENCY _____		❑ OTHER _____

ADDITIONAL IV THERAPY	SERVICES REQUESTED
PICC LINE CARE	❑ Weekly ❑ Monthly Orders:
LABS	❑ Weekly ❑ Monthly Orders:
WOUND CARE	❑ Weekly ❑ Monthly Orders:
PHARMACOKINETIC DOSING	❑ Weekly ❑ Monthly Orders:
SPECIAL IV INSTRUCTIONS	

PRESCRIBER INFORMATION

Physician's Name (Please Print): _____ NPI#: _____
Address: _____ License#: _____
City, State, Zip: _____ DEA#: _____
Phone: _____ Fax: _____ Contact Name: _____
Physician's Signature: _____ Date: _____

I authorize Dr Ike's Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.