DIXIE Vital Care
Infusion Pharmacy Services

Referral Form

DIXIE INFUSION PHARMACY,
DBA Dixie Vital Care
311 Landrum Pl. Suite 600
Clarksville, TN 37043 - 6319
Tel: 931-241-5655
Fax: 931-241-5654

Patient Information

Last Name	First Name	SSN	DOB
Home Address	City	State	Zip
Home Phone	Work Phone	Parent/Guardian	
Shipping Address	City	State	Zip
Other Pertinent Information			

Delivery Information

Today's Date:	Date & Time Needed:	Deliver to:
		☐ Patient's Home ☐ MD Office/Clinic ☐ Patient's Work ☐ Other: _____

Pharmacy Insurance Information

Primary Insurance:	Rx Bin:
ID Number:	Group Number:
Secondary Insurance:	Rx Bin:
ID Number:	Group Number:

Physician Information

Prescriber Name:		DEA:	
Licence:		Office Contact:	
Address:	City:	State:	Zip:
Phone Number:		Fax Number:	

Diagnoses Information

- ☐ Relapsing-Remitting Multiple Sclerosis, 340.00
- ☐ Patient is ***NON-AMBULATORY***
- ☐ Other _____ ICD9_____

Medications *(You may tape Prescription here prior to faxing)*

Medication	Strength	Directions	Quantity	Refills
☐ **Avonex®**	30 mg	20mg IM QW		
☐ **Copaxone®**	20 mg	20mg SQ QD		
☐ **Rebif®**	☐ 22 mg ☐ 44 mg	Inject Rebif SQ TIW		
☐ **Rebif Titration Pak®**				
☐ **Betaseron®**	0.25 mg	0.25mg SQ QOD		
☐				
☐				
☐				
☐				

Special Instructions/Information

Prescriber Information

Physician: _____

Contact Name: _____ Phone #: _____ Fax #: _____ NPI #: _____

Office Address: _____ City: _____ State: _____ Zip: _____

I authorize Dixie Vital Care and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Physician's Signature: _____ DEA #: _____ Date _____