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

Pharmacy Insurance Information

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

Physician Information

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

Diagnoses Information

Primary Dx:	ICD-9:	Secondary Dx:	ICD-9:

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

Medication	Strength	Directions	Quantity	Refills
☐ Abraxane				
☐ Adriamycin				
☐ Aredia				
☐ Avastin				
☐ Bleomycin				
☐ Camptosar				
☐ Carboplatin				
☐ Cisplatin				
☐ Cytarabine				
☐ Cytoxan				
☐ Dacogen				
☐ Doxorubicin				
☐ Eloxatin				
☐ Erbitux				
☐ Etoposide				
☐ Faslodex				
☐ Fludaribine				
☐ Fluorouracil				
☐ Gemzar				
☐ Herceptin				
☐ Hycamtin				
☐ Ixempra				
☐ Leucovorin				
☐ Lupron				
☐ Ifex				
☐ Mesna				
☐ Methotrexate				
☐ Mitomycin				

Medication	Strength	Directions	Quantity	Refills
☐ Navelbine				
☐ Novantrone				
☐ Remicade				
☐ Rituxan				
☐ Taxol				
☐ Taxotere				
☐ Vectibix				
☐ Velcade				
☐ Vidaza				
☐ Vinblastine				
☐ Vincristine				
☐ Zoladex				
☐ Zometa				
Pre-Medications				
☐ Aloxi				
☐ Anzemet				
☐ Benadryl				
☐ Dexamethasone				
☐ Emend				
☐ Kyrtil				
☐ Tagamet				
☐ Zofran				
Biologicals				
☐ Aranesp				
☐ Procrit				
☐ Neulasta				
☐ Neupogen				
☐ Neumega				

Delivery Information

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

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 _____