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

Primary Dx	ICD-9
Secondary Dx	ICD-9
Tirtiary Dx	ICD-9

Revlimid Required Information

- ☐ Adult Female - NOT of Childbearing Potential
- ☐ Adult Female - Childbearing Potential
- ☐ Adult Male
- ☐ Female Child - NOT of Childbearing Potential
- ☐ Female Child - Childbearing Potential
- ☐ Male Child

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

Medication	Strength	Directions	Quantity	Refills
☐ Xeloda®				
☐ Nexavar®				
☐ Sprycel®				
☐ Gleevec®				
☐ Tarceva®				
☐ Sutent®				
☐ Zolinza®				
☐ Matulane®				
☐ Thalomid®				0
☐ Revlimid®				0
☐ Tykerb®				
Others: ☐				
☐				
☐				
☐				

Celgene® Authorization Number
*Required for Revlimid® & Thalomid®

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 _____