

Vyepti Referral Form

Fax completed form to: (405) 418-4442

OptionOne Infusion

4150 S. Harvard Ave., Suite G2 • Tulsa, OK 74135

Phone: (405) 548-4848 Toll Free: 888-848-4588



PATIENT INFORMATION

Patient Name:	Date of Referral:	Date of Birth:	<input type="checkbox"/> M <input type="checkbox"/> F
Address:	City, State, Zip:	SSN:	
Phone:	Work Phone:	Primary Language:	
Caregiver Name (if other):	Relationship:	Phone:	
Emergency Contact:	Relationship:	Phone:	

INSURANCE INFORMATION

Please attach and fax: 1. Insurance card(s) and demographic information 2. Recent clinical assessment note or H&P 3. Current medication list

OTHER DOCUMENTATION

<p>MEDICAL HISTORY:</p> <p><input type="checkbox"/> Allergies <input type="checkbox"/> NKDA</p> <p>If yes, list: _____</p> <p>Height: _____ <input type="checkbox"/> in <input type="checkbox"/> cm</p> <p>Weight: _____ <input type="checkbox"/> lbs <input type="checkbox"/> kg</p> <p>Date Taken: _____</p>	<p>PRESCRIPTIONS AND ORDERS:</p> <p>IV Access:</p> <p><input type="checkbox"/> Peripheral <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> Vyepti 100 mg every 3 months <input type="checkbox"/> Vyepti 100 mg every 3 months</p> <p>Refills 1x/year unless otherwise noted: _____</p> <hr/> <p>PRIMARY DIAGNOSIS</p> <p>Diagnosis (Please indicate ICD 10-CM code & description):</p>
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Adverse and Anaphylactic Reactions will be treated per OptionOne protocol.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Signature: _____

Date: _____

PHYSICIAN INFORMATION

Physician Name:	Lic. #:	DEA #:	
Practice Name:	NPI #:	Specialty:	
Address:	City:	State:	Zip:
Nurse Contact:	Phone:	Fax:	
Physician Signature:	Date:		

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