# Vyepti Referral Form

**Fax completed form to: (405) 418-4442**

OptionOne Infusion
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mosaic infusion solutions

OptionOne INFUSION An Amerita Company

## PATIENT INFORMATION

| | | | |
|---|---|---|---|
| Patient Name: | Date of Referral: | Date of Birth: | ☐ M ☐ 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

**MEDICAL HISTORY:**

☐ Allergies ☐ NKDA

If yes, list:

Height: _____ ☐ in ☐ cm

Weight: _____ ☐ lbs ☐ kg

Date Taken: _____

**PRESCRIPTIONS AND ORDERS:**

**IV Access:**

☐ Peripheral ☐ Other: _____

☐ Vyepti 100 mg every 3 months ☐ Vyepti 100 mg every 3 months

Refills 1x/year unless otherwise noted: _____

**PRIMARY DIAGNOSIS**

Diagnosis (Please indicate ICD 10-CM code & description):

***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: | |

By signing this form and utilizing our services, you are authorizing Amerita and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.