INFUSION REFERRAL FORM

Asheville Neurology Specialists, PA
31 Dogwood Road, Asheville, NC 28806
Phone: (828) 210-9300   Fax: (828) 210-9319

Please select Infusion service being requested:

[ ] Tysabri   [ ] Ocrevus   [ ] Lemtrada   [ ] Solumedrol

Diagnosis (w/ ICD-10 code):____

Patient Name: ____DOB: ___________________

Address: ____City: ___________________________

State: _________ Zip Code: __________________________ Email: ___________________________________

Home Telephone#:__________________________________ Mobile #: _______________________________

Please include the following with this form: ***(appointment may be delayed if not received with this form)***

[ ] Physician Order *(with dosing and frequency)*
[ ] Copy of insurance card *(front and back)*
[ ] Prior authorization # *(if applicable w/ date range):* ____
[ ] Enrollment ID information in Programs *(i.e.: Touch Program or Ocrevus Access Solutions)*
[ ] Free Drug or Copay Assistance Information *(if applicable)*
[ ] Date of last infusion or new start: ____________________________________
[ ] Medical Records *(include the office note referencing infusion start up OR last infusion office note at previous infusion center)*
[ ] Lab work related to patients condition *(i.e.: JCV, CRP, Hep B)*

Referring Physician: _____________________________________ NPI #: ______________________________

Name of Practice/ Facility: ____________________________Group Practice NPI #: ______________________

Referring Physician Phone #: _______________________________Fax #: ______________________________

Contact Name: ____ Extension: _______________________