



WWW.VASCOINFUSION.COM
 PH: 602-346-0204 FAX: 877-637-6691

- New Referral
 Restart
 Medication/ Order Change (New Order Required)
 Benefits Verification Only
 D/C Infusions *indicate name of drug(s)

Vasco Infusion can accept only original prescription drug orders from patients, and faxed prescriptions from the prescribing practitioners.

PATIENT INFORMATION

PHYSICIAN INFORMATION

Name: _____
 DOB: _____ SS# _____
 Phone # _____
 Email: _____

Referring Physician: _____
 Practice Address: _____
 Office Contact: _____
 Contact Phone # _____ Contact Fax # _____
 NPI / TIN: _____

NEULASTA MEDICATION ORDERS

Patient Weight: _____ kg
 Dosing: 6 mg SQ _____ weeks
 Other _____

INDICATION/DIAGNOSIS

NOTES (ADDITIONAL INFO)

- Leukocyte growth factor
 Other

*ICD-10 _____ required

 Referring Physician's Signature Date

REQUIRED DOCUMENTATION

- Recent Office notes (along with any therapies tried and outcomes)
 Current Medication List
 History and Physical Report
 Lab Results
 Insurance Cards (front and back)
 Demographic Sheet

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

- HepB Surf Ag (w/in 12 months)
 HepB Core Ab (w/in 12 months)
 PPD Results (w/in 12 months)
 Comprehensive Metabolic Panel, CBC with differential w/in past 3 months

APPOINTMENT DATE & TIME: _____

FOR OFFICE USE ONLY