



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# _____
 Sodium bisulphate allergy: Yes No
 Phone # _____
 Email: _____

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

RADICAVA MEDICATION ORDERS

- INITIAL CYCLE
 Infuse 60mg over 60 minutes for 14 consecutive days on, 14 consecutive days off

 SUBSEQUENT CYCLES
 Infuse 60mg over 60 minutes for 10 out of 14 days on, followed by 14 consecutive days off

INDICATION/DIAGNOSIS

NOTES (ADDITIONAL INFO)

- G12.21 Amyotrophic Lateral Sclerosis (ALS)
 Other *(please specify in notes)*

***ICD-10 _____ required**

 Referring Physician's Signature

 Date

REQUIRED DOCUMENTATION

- | | |
|---|--|
| <input type="checkbox"/> Recent Office notes - along with any therapies tried and outcomes
- signs of LMN degeneration | <input type="checkbox"/> History and Physical Report |
| <input type="checkbox"/> Lab Results - including neuro imaging | <input type="checkbox"/> ALSFRS - R |
| <input type="checkbox"/> Insurance Cards (front and back) | <input type="checkbox"/> Power of attorney (if applicable) |
| <input type="checkbox"/> Demographic Sheet | <input type="checkbox"/> Home Infusion mandate: |
| <input type="checkbox"/> Current Medication List | - Home bound status letter from doctor |
| | - Specific documentation in clinicals |

APPOINTMENT DATE & TIME: _____

FOR OFFICE USE ONLY