REQUEST FOR IDPN/ IPN SERVICES

DATE OF REQUEST / /

DELIVERIT™ Infusion & Specialty
Phone +1.832.939.8137
Fax: +1.832.939.8128

Patient Demographic Information

(Or Attach Face Sheet from Patient Chart)

Patient Name		DOB		Gender	Male ☐ Female ☐	Weight	____lbs ☐ kg ☐
SSN		Phone		Allergies			
Address		City		State		Zip Code	

Patient Insurance Information

(Or Attach Copies of Patient's Insurance Card)

Primary Insurance		Name of the Insured		Relationship	
Member ID#		Group #		Insurance Phone #	
Secondary Rx Carrier		Rx ID #		Rx Group #	

TREATMENT

☐ In-Center
☐ In-Home

☐ M / W / F ☐ T / TH / S Time: _____ am / _____ pm

Requested Infusion Time (Hours): ☐ 2.25 ☐ 2.75 ☐ 3.25 ☐ 3.75 ☐ Other: _____

Treatments per Week: ☐ 3 Times/Wk ☐ 4 Times/Wk ☐ 5 Times/Wk ☐ 6 Times/Wk ☐ 7 Times/Wk

FORMULA

IDNP Formula (check box)	☐ Total Volume 750ml Amino Acid 10% 350ml Dextrose 70% 150ml Fat Emul. 20% 250ml	☐ Total Volume 1 Ltr Amino Acid 10% 500ml Dextrose 50% 250ml Fat Emul. 20% 250ml	☐ Other: Amino Acid 10% _____ml Dextrose _____%_____ml Lipids_____%_____ml Total Volume _____mls

REQUIRED DOCUMENTATION

1. Complete Entire Application and Fax Form.
2. Please Fax this Form with Requested Items to: 832-939-8128

Please Obtain & Provide The Required Items Below And Return With This Form.

- ☐ Face Sheet
- ☐ Routine Monthly Composite Lab Work (Current Month & Previous 2 Months)
- ☐ Supplements Trialed (Dates & Length of Trial) _____
- ☐ Nutrition Plan of Care / Progress Note
- ☐ Weight Loss _____ lbs/kgs over _____ Month(s) OR % of Weight Loss over 3 Months _____ 6 Months _____
- ☐ Date of First Dialysis Treatment _____/_____/_____
- ☐ Copy of Insurance Card (front & back)

Admit Date: _____/_____/_____

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Prescriber Insurance Information

Prescriber Name		NPI#		Office #		Fax #	
Address		City		State		Zip Code	

☐ I Authorize DeliverIt specialty pharmacy to initiate Prior Authorizations on my behalf.

☐ DAW (Dispense as written).

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. No stamped signatures will be accepted. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through DeliverIt Group, this prescription shall be forwarded to an eligible pharmacy.

Date

Prescriber's Signature

X _____

Please fax all information to (877)993-3548 or call (832)939-8128 for assistance