IPF, Chronic Fibrosing ILD and SSc-ILD
REFERRAL FORM

FAX REFERRAL TO: +1(844) 277-0049 **PHONE: +1(844) 650-5802**

IV Solutions RX

1 PATIENTS INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ **DOB:** _____ **Gender:** ☐ MALE ☐ FEMALE

Address: _____ **City/State/Zip:** _____

Primary Phone: _____ **Email:** _____ **SSN:** _____ **Primary Language:** _____

Emergency Contact: _____ **Relationship to Patient:** _____ **Phone:** _____

2 INSURANCE *(Please attach **If Available** a copy of the Patients' insurance card(s) Front/ Back)*

Primary Insurance: _____ **Policy No:** _____ **Group:** _____

Primary RX Insurance:_____ **ID No:**_____ **RX GRP:**_____ **RX BIN:**_____ **RX PCN:**_____

3 DIAGNOSIS AND CLINICAL INFORMATION

Diagnosis (ICD-10):

☐ J84.10 Pulmonary Fibrosis, Unspecified ☐ J84.112 Idiopathic Pulmonary Fibrosis

☐ J84.170 Interstitial Lung Disease with a progressive fibrotic phenotype ☐ M34.81 Systemic Sclerosis with lung involvement

☐ Other Code: _____ Description _____

Prior Therapy: ☐ Yes, current or most recent therapy: _____ ☐ No Prior Therapies

Patient Clinical Information: Is patient on oxygen therapy? ☐ Yes ☐ No

Drug Allergies:_____ ☐ NKDA **Ht:** _____in/cm **Wt:** _____lbs/Kg

4 PRESCRIPTION INFORMATION

MEDICATION	STREGNTH	DOSING & DIRECTIONS	QUANTITY	REFILLS
☐ **Esbriet** *(pirfenidone)*	☐ 267 mg	☐ **Initial Titration Dose Directions:** **Days 1 through 7:** Take one capsules/tablet by mouth three times daily with food. **Days 8 through 14:** Increase to two capsules/tablets by mouth three times daily with food. **Day 15 and onward:** Increase to three capsules/tablets three times daily with food.	Q.S	~~0~~
		☐ **Maintenance Dose:** Take three capsules/tablets by mouth three times daily with food.	Q.S	1 YEAR
	☐ 801 mg	☐ **Maintenance Dose:** Take one tablet (801 mg) by mouth three times daily with food.	Q.S	1 YEAR
		☐ **Other:** _____	_____	_____
☐ **Pirfenidone**	☐ 267 mg	☐ **Initial Titration Order Directions:** **Days 1 through 7:** Take one tablet by mouth three times daily with food. **Days 8 through 14:** Increase to two tablets by mouth three times daily with food. **Day 15 and onward:** Increase to three tablets three times daily with food.	Q.S	~~0~~
		☐ **Maintenance Order:** Take three tablets by mouth three times daily with food.	Q.S	1 YEAR
	☐ 801 mg	☐ **Maintenance Dose:** Take one tablet (801 mg) by mouth three times daily with food.	Q.S	1 YEAR
		Other: _____	_____	_____
☐ **Ofev** *(nintedanib)*	☐ 150 mg ☐ 100 mg	Take one capsule by mouth every 12 hours as directed with food.	Q.S	1 YEAR
		Other: _____	_____	_____
☐ **OTHER:** _____	_____	_____	_____	_____

5 PRESCRIBER SIGNATURE REQUIRED *(STAMP SIGNATURE NOT ALLOWED)*

Prescriber Name: _____ **Title:** ☐ MD ☐ DO ☐ ND ☐ PA ☐ APRN **NPI:** _____

Address: _____ **City/State/Zip:** _____

Phone: _____ **Fax:** _____ **Contact Person:** _____

☐ **DISPENSE AS WRITTEN** ☐ **BRAND MEDICALLY NECESSARY** ☐ **DO NOT SUBSTITUTE** ☐ **NO SUBSTITUTION /** ☐ **DAW /** ☐ **MAY NOT SUBSTITUTE** **Prescriber's Signature:** _____ **Date:** _____	☐ **May Substitute /** ☐ **Product Selection Permitted /** ☐ **Substitution Permissible** **Prescriber's Signature:** _____ **Date:** _____

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution." NY & IA: electronic prescription required.

Prescribers are to comply with state-specific prescription regulations, which may include requirements for electronic prescribing, generic substitution, authorized prescription formats, and fax language. Noncompliance with these requirements may prompt follow-up communication with the prescriber.

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record.
I authorize IV Solutions RX and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future refills of the same prescription for the patient listed above. I understand that I can revoke the designation at any time by providing written notice to IV Solutions RX.
CONFIDENTIALITY NOTICE: The information contained in this transmission may contain confidential information, including patient information protected by federal and state privacy laws. It is intended only for the use of the person(s) named above. If not the intended recipient, you are hereby notified that any review, dissemination, distribution, or duplication of this communication is strictly prohibited. If you are not the intended recipient, please contact the sender by reply email to **info@ivsolutionsrx.com** and destroy all copies of the original message.

THANK YOU FOR YOU TRUSTING US WITH YOUR PATIENTS SPECIALTY CARE *#welcome to our family*