



PHYSICIAN ORDER FORM

P: 331-236-0610 | **F:** 331-314-8989

PATIENT INFORMATION

Fax completed form, insurance information, and clinical documentation to 331-314-8989

Name:	DOB:	Gender: ☐ Female ☐ Male	
Address:	City:	State:	ZIP:
Phone:	Email:	Height:	☐ inches ☐ cm
		Weight:	☐ lbs. ☐ kg
Allergies:			

Diagnosis Code ICD-10 (required):

Diagnosis Description:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy

Next Treatment Date:

PHYSICIAN INFORMATION

Prescriber Name:	Phone:	Fax:
Office Contact:		Email:
Address:	City:	State:
		ZIP:
NPI #:	DEA#:	Tax ID:

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Additional orders: _____

Lab orders: _____ Frequency: _____

Required labs to be drawn by ☐ LIVbetter ☐ Referring Provider

As required by your state, Prescriber to check "Dispense as written" or handwritten "Brand Medically Necessary" and sign to prevent generic substitution.

☐ Dispense as written

PRESCRIBER SIGNATURE

By signing this form and utilizing our services, you are authorizing *LIVbetter Infusions*, and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Prescriber Signature: X

Date:



COMPREHENSIVE SUPPORT FOR INFUSION/INJECTION THERAPY

PATIENT INFORMATION

Name:

DOB:

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- ☐ Include signed and completed order (MD/prescriber to complete page 1)
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's medication list
- ☐ Supporting clinical notes (H&P) to support primary diagnosis
- ☐ Labs attached (if applicable)
- ☐ Diagnostics attached (if applicable)
- ☐ Medical necessity (if applicable): _____