VirginiaPremier™
Powered by VCU Health

exactus™
PHARMACY SOLUTIONS
Experts in pharmacy management

Fax: 1-866-458-9245
Phone: 1-866-458-9246
E-Prescribe: Exactus Pharmacy Solutions

Intravenous immunoglobulin (IVIG) is available upon Prior Approval through Envision.
Please call 1-855-872-0005 before ordering from Exactus and using this form

Patient Information

Name (First, MI, Last) _____ Sex ☐M ☐F DOB (MM/DD/YYYY) _____
Address_____ City_____
State_____ ZIP_____ Email_____
Home/Cell Phone_____ Work Phone_____ Best Contact Time_____

Insurance Information (Complete this section or provide a copy of all insurance cards Front AND Back)

Primary Insurance_____
Cardholder_____
Relationship to Cardholder _____
Insurance Company Phone _____
Policy#_____
Group#_____
Prescription Drug Insurer _____

Secondary Insurance_____
Cardholder_____
Relationship to Cardholder _____
Insurance Company Phone _____
Policy#_____
Group#_____
Prescription Drug Insurer _____

Prescriber Information (SPECIAL NOTE: New York Prescribers please submit prescription on an original NY State prescription blank. For all other states, if not faxed, prescription must be submitted on state-specific blank, if applicable for your state.

Prescriber Name (First, Last) _____ Specialty_____
Practice Name_____ Office Contact_____
Address_____
City_____ State_____ ZIP_____
Phone_____ Fax_____
Medicaid/Medicare Provider#_____ Tax ID#_____
State License# _____ UPIN/NPI#_____

Clinical Information

Primary Diagnosis code (required) _____
Secondary Diagnosis (optional) _____ Date of Diagnosis or Years with Disease_____
Prior Medications _____

Prescription Information (The prescription is only valid if received by fax.)

☐ Bivigam™	☐ Flebogamma® DIF	☐ Gammaked™	☐ Octagam®
☐ Carimune® NF	☐ Gammagard® Liquid	☐ Gammaplex®	☐ Privigen®
☐ Flebogamma®	☐ Gammagard® S/D	☐ Gammunex®-C	➧ **QTY**_____
			☐ Refills_____

SIG:_____

_____

Ship to (as indicated by applicable address information above): ☐Prescriber ☐Patient
Requested Ship Date_____

Prescriber Signature (Dispense as Written) _____ DATE_____

Supervising Physician Signature (if applicable) Name_____ DATE_____