Arthritis, Rheumatic, & Bone Disease Associates
An Affiliate of Trabecular Medical Group

IDYLLIC
infusion treatment center

2301 Evesham Road - Building 800, Suite 115
Voorhees, New Jersey 08043
T. (856) 996-0145
F.(856)770-8271

MEDICATION REQUESTED	
DATE:	
NAME OF DRUG BEING REQUESTED: **(IDYLLIC will be responsible for providing requested drug)**	
REFERRING PROVIDER INFORMATION	
Requesting Provider Name and NPI Tax ID#	**Name:** **NPI:** **Tax ID#**
Phone Number	
Fax Number	
Practice Contact (Name/Extension)	Phone Number: Ext:
We will gladly remind your patient to schedule routine follow-up visits with your office. **Return to Referring Provider (frequency): EVERY _____ WKS / MOS**	
PATIENT INFORMATION	
Patient Name	
Date of Birth	/ /
Height/Weight	
Preferred Treatment Location	☐ Voorhees ☐ Moorestown ☐ Wall/Manasquan ☐ Sewell ☒ Hamilton ☐ Galloway
Primary Care Physician (Name / Phone Number)	PCP Name: PCP Phone Number:

SECOND PAGE MUST BE COMPLETED

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PLEASE BE SURE TO SEND ALL REQUIRED INFORMATION LISTED BELOW

ADDITIONAL DOCUMENTATION REQUIRED

- ❏ Primary Diagnosis code: _____
- ❏ Please attach a copy of medication order to this document when transmitting to ARBDA/IDYLLIC. Prescription should include standard information as well as specific instructions if loading doses of desired RX is required. ** NOTE ** Please do **NOT** provide a prescription to the patient as they may become confused and attempt to fill at their local/specialty pharmacy.
- ❏ Copy of Primary and Secondary Medical/Pharmacy Insurance Cards (Please enclose both FRONT & BACK)
- ❏ Is this patient ambulatory YES / NO
  - ❏ Is a Wheelchair required YES / NO
- ❏ History of Infusion / Injection treatments (if applicable) and summary of medical history / treatment plan.
- ❏ MOST RECENT and/or Qualifying Labs (based on specific drug)
- ❏ Verification that your patient was issued a RX by the referring provider for an EpiPen and that patient was instructed to bring the EpiPen with them to the injection/infusion appointment (if required).
- ❏ **Please notify your patient that our office will contact them when we are ready to schedule. They do NOT need to call our office to set up an appointment.**
- ❏ Does this patient require premedication(s)? If so, please indicate below.
  - ❏ TYLENOL® (APAP) 500 mg. tablets - 2 tabs PO x 1
  - ❏ SOLU-MEDROL® (or equivalent glucocorticoid) - 100 mg. IVP x1
  - ❏ ZYRTEC® (cetirizine) 10 mg. Tablets - 1 tab PO x 1
  - ❏ Other: _____

PLEASE NOTE: OUR OFFICE PROVIDE & DISPENSE ALL REQUIRED MEDICATIONS
ARBDA/IDYLLIC NPI: 1427622661 **TAX ID:** 85-1604336

Please contact our office if medication will be discontinued.