



2301 Evesham Road - Building 800, Suite 115 Voorhees, New Jersey 08043 T. (856) 996-0145 F.(609)751-9799

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:	
Contact Email		
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

## 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.
$\square$ TYLENOL $^{\circledR}$ (APAP) 500 mg. tablets – 2 tabs PO x 1
☐ SOLU-MEDROL® (or equivalent glucocorticoid) - 100 mg. IVP x1
🖵 ZYRTEC <sup>®</sup> (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.