



Referral Request for Clinical and Adherence Support Therapy Services

and collaborative care provided by specially trained **RxAIM Support LLC** staff that ensures *patients get the greatest benefit and outcomes from their medication and prescribed therapy plan.*

Trained **RxAIM Support LLC** staff works collaboratively with physicians and other health care providers to help patients understand their medications and use them in a safe and effective manner to maximize outcomes and satisfaction.

NOTE: Only the Referring Physician or Health Care Provider may use this approved and certified form. Please complete and send to our secure fax: 1-844-435-7791.

PATIENT INFORMATION

Last Name	First Name	Date of Birth	
Street Address			
City		State	Zip
Phone Number		Mobile Phone Number	

REFERRING PHYSICIAN INFORMATION

Physician Name	NPI Number
Office Phone Number	Office Fax Number

SELECT Clinical Intervention Module Chronic Disease State

___ Multiple Sclerosis	___ Hepatitis C
___ Biologics (RA, PA, Crohn's, other)	___ HIV-AIDS
___ Special Request:	___ Oral Oncology

Please indicate your selection below:

- I refer the patient listed above to receive Clinical & Adherence Therapy Services
- Other/Comments: _____

Referring Physician Signature	Date
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