BIOLOGIC INJECTIONS TRANSFER FORM

Outside of AllerVie Health

AllerVie Health allows your biologic injections to be transferred to another office or practice under the agreed to supervision of a licensed physician. Please sign and fully complete the form below to transfer your injections to another facility.

- I have read and signed the consent for the Administration of Biologic Injections.
- I understand that I will receive injections and use all off my biologic vials currently on hand at AllerVie Health prior to transferring to the facility listed below. I also understand vials will not be transferred until this form is received and signed by the supervising physician designated below.
- I wish to have my injections administered at the medical facility below. I have confirmed that the staff is willing and able to provide biologic injections and able to recognize and treat immediate or delayed adverse reactions that may result from the injections. I agree that I will not attempt to administer biologic injections to myself, nor will I permit anyone who is not a licensed physician or under the supervision of a licensed physician, to administer my biologic injections. I further agree to notify this office if I transfer my care and or vials to any medical facility other than the one I designate below.
- I understand that I am responsible for changing the shipping address with my specialty pharmacy to that of the facility below. I also understand that I may call AllerVie Health at any time with questions or if issues develop, and that I may return to this office for the administration of my injections if needed.

Patient Name: ______________________________ **Patient Date of Birth:** ____________

Parent/Guardian Name (If Applicable): ______________________________

Patient or Parent/Guardian Signature: ______________________________ **Date:** ____________

☐ I agree to administer the biologic injections for this patient in my office. I am aware of the storage requirements for the biologic and agree to receive and appropriately store the drug. I also agree to monitor the patient for the appropriate wait time after each injection.

Supervising Physician Signature: ______________________________ **Date:** ____________

Supervising Physician Name: ______________________________

Street Address: ______________________________

City/ State/ Zip: ______________________________

Phone: ______________________________

THIS FORM SHOULD BE COMPLETED AND FAXED TO YOUR LOCAL ALLERVIE HEALTH OFFICE.

PLEASE CONTACT YOUR LOCAL OFFICE WITH ANY QUESTIONS.