BioTek reMEDys
www.Biotekrx.com

Hematology Referral Form

Feel free to use all or part of the form when faxing us a referral

2 Penns Way, Ste#404
New Castle, DE 19720
Phone: (877) 246-9104
Fax: (888) 963-8122

PATIENT INFORMATION (Complete or use existing chart)

Patient Name: ________________________________
Address: ________________________________
City, State, Zip: ________________________________
Phone: ________________ 2nd Phone: ___________
DOB: __________________ Gender: Male Female
Weight: Ht: Allergies:

PRESCRIBER INFORMATION

Prescriber Name: ________________________________
State License: ________________ NPI #: ________________
DEA: __________________ Phone: ________________
Address: ________________________________
City, State, Zip: ________________________________
Contact Person: ______________ Phone: ______________

INSURANCE INFORMATION - INSTEAD - just send us a copy of the patient's prescription / insurance cards (front & back)

Primary Insurance: ________________________________
City, State, Zip: ________________________________
Member ID #: ________________________________
Plan #: ________________________________
Group #: ________________________________
Phone: ________________________________

RX Card (PBM): ________________________________
BIN: ________________ PCN: ________________
City, State, Zip: ________________________________
Group #: ________________________________
Phone: ________________________________

DIAGNOSIS /CLINICAL INFORMATION

☐ D66 Hereditary factor VIII deficiency (hemophilia A)	☐ D68.311 Acquired hemophilia	☐ D59.5 Paroxysmal nocturnal hemoglobinuria
☐ D67 Hereditary factor IX deficiency (hemophilia B)	☐ D68.4 Acquired coagulation factor deficiency	
☐ D68.0 von Willebrand's disease	☐ D68.59 Other Primary Thrombophilia	**Hemophilia Severity:**
☐ D68.1 Hereditary factor XI deficiency (hemophilia C)	☐ D59.3 Hemolytic-uremic syndrome	**vWD Type:**
☐ Other Code:	Description:	

Needs by Date: Ship to: Patient Office Other:

PRESCRIPTION / ADMINISTRATION

Biologic Product	Route	Dose	Directions	Quantity	Refills
Brand:	☐ IV			☐ 1 month ☐ 3 months	#:________
Medications	**Route**	**Dose**	**Directions**	**Quantity**	**Refills**
☐ Stimate®	☐ NS	☐ 150mcg ☐ 300mcg		☐ 1 month ☐ 3 months	#:________
☐ Amicar®	☐ Tablet ☐ Syrup	__________ MG/KG		☐ 1 month ☐ 3 months	#:________
☐ Other:					
Flush					
☐ Saline 10mL	☐ IV	☐ 3 mL ☐ 5 mL ☐ ____________	☐ Before and after infusion ☐ ________________________	☐ 1 month ☐ 3 months	#:________
☐ Heparin - 10 Units/ml ☐ Heparin - 100 Units/ml	☐ IV	☐ 3 mL ☐ 5 mL ☐ ____________	☐ After infusion ☐ ________________________	☐ 1 month ☐ 3 months	#:________
Anaphylaxis					
☐ Diphenhydramine	☐ IV ☐ PO ☐ IM	☐ 25mg ☐ 50mg ☐ ____________	☐ Pre-Med: ______________ ☐ ________________________	☐ W/ ea. Infusion ☐ ____________	#:________
☐ Epinephrine	☐ IM ☐ SQ	☐ Adult 1:1000 0.3mL ☐ Peds 1:2000 0.3mL	☐ PRN Anaphylaxis ☐ Repeating Dose: __________	☐ Once ☐ ____________	#:________
☐ Epipen (2 pack)	☐ IM ☐ SQ				#:________
Nursing					
Nursing: ☐ YES ☐ No	Access:________________________________				

SIGNATURE

X ________________________________
Product Substitution Permitted

X ________________________________
Dispense As Written

Important Information: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee.

Fax completed form to: (888) 963-8122 Thank you for using BioTek reMEDys

☐ Check here for STAT referral (patient needs product within 48 hours)