BioTek reMEDys

www.Biotekrx.com

Immune Globulin Referral Form

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Phone: (877) 246-9104
Fax: (888) 963-8103

PATIENT INFORMATION (Complete or fax 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 patients prescription / insurance cards (front & back)

Primary Insurance: ____________________________
City, State, Zip: ______________________________
Plan #: ____________________________________
Group #: ___________________________________
Phone: ____________________________________

RX Card (PBM): _____________________________
BIN: _________________ PCN: ________________ _
City, State, Zip: _____________________________
Group #: ___________________________________
Phone: ____________________________________

DIAGNOSIS /CLINICAL INFORMATION

☐ D80.0 Congenital Hypogammaglobinemia	☐ D81.9 SCID (unspecified)	☐ D83.9 Common Variable Immunodeficiency
☐ G35 MS (Relapsing Remitting)	☐ G61.0 GBS	☐ G61.81 CIDP
☐ G61.89 MMN	☐ G70.00 MG W/O acute exacerbation	☐ G70.01 MG with acute exacerbation
☐ M33.20 Polymyositis	☐ M33.90 Dermatomyositis	
☐ Other Code:	Description:	

Needs by Date: Ship to: Patient Office Other:
Lab Orders:

PRESCRIPTION / ADMINISTRATION

Medication	Route	Dose	Directions	Refills
Immune Globulin Brand (any): ☐ Dispense As Written	☐ SC ☐ IM ☐ IV	______ grams ______ mg/kg		#:________

Pre-Meds	Route	Dose	Directions	Quantity	Refills
☐ Acetaminophen	☐ PO	☐ 325mg ☐ 500mg ☐ __________	☐ Pre_Med: ________________ ☐ ______________________	☐ w/ea. Infusion ☐ ____________	#:________
☐ Diphenhydramine	☐ PO ☐ IM ☐ IV	☐ 25mg ☐ 50mg	☐ Pre_Med: ________________ ☐ PRN Reaction:______________	☐ w/ea. Infusion ☐ ____________	#:________
☐ methylprednisone					
☐ Ondansetron					
☐ Reglan					
☐ 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				#:________
☐ Other:					

Vascular Access method ☐ Peripheral ☐ Central ☐ Other ____________________________

SIGNATURE

X ____ Date: ______________

Product Substitution Permitted

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Fax completed form to: (302) 544-5018 Thank you for using BioTek reMEDys