

PATIENT INFORMATION (Complete or use existing chart)	PRESCRIBER INFORMATION
Patient Name: _____ Address: _____ City, State, Zip: _____ Phone: _____ 2 nd Phone: _____ DOB: _____ Gender: Male Female Weight: _____ Ht: _____ Allergies: _____	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		
<input type="checkbox"/> D66 Hereditary factor VIII deficiency (hemophilia A)	<input type="checkbox"/> D68.311 Acquired hemophilia	<input type="checkbox"/> D59.5 Paroxysmal nocturnal hemoglobinuria
<input type="checkbox"/> D67 Hereditary factor IX deficiency (hemophilia B)	<input type="checkbox"/> D68.4 Acquired coagulation factor deficiency	
<input type="checkbox"/> D68.0 von Willebrand's disease	<input type="checkbox"/> D68.59 Other Primary Thrombophilia	Hemophilia Severity:
<input type="checkbox"/> D68.1 Hereditary factor XI deficiency (hemophilia C)	<input type="checkbox"/> D59.3 Hemolytic-uremic syndrome	vWD Type:
<input type="checkbox"/> Other Code: _____	Description: _____	

Needs by Date: _____ Ship to: Patient Office Other:

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

SIGNATURE	
X _____ Product Substitution Permitted	X _____ Dispense As Written

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

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