BioTek reMEDys
www.Biotekrx.com

# Hematology Referral Form

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

## SIGNATURE

X _____
Product Substitution Permitted

X _____
Dispense As Written



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

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