BioTek reMEDys®

HEMATOLOGY®

Please Fax Completed Form To: 800-783-9146

PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION
Name: ______ DOB: ______	Prescriber Name: ______
Address: ______	State License: ______
City, State, Zip: ______	NPI #: ______ DEA: ______
Phone: ______ Alt. Phone: ______	Address: ______
Email: ______ SS#: ______	City, State, Zip: ______
Gender: ☐M ☐F Weight: ______(lbs) Ht: ______	Phone: ______ Fax: ______
Allergies: ______	Office Contact: ______ Phone: ______

INSURANCE INFORMATION – OR – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: ______	RX Card (PBM): ______
City, State, Zip: ______	BIN: ______ PCN: ______
Plan #: ______	City, State, Zip: ______
Group #: ______	Group #: ______
Phone: ______	Phone: ______

CLINICAL INFORMATION

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

Needs by date: Ship to: ☐ Patient ☐ Office ☐ Other: ______

(DRUG NAME) ORDERS – this section may not be needed)

Biologic Product	Route	Dose	Directions	Quantity	Refills
Brand:	☐ IV			☐1 month ☐3 months	
Medications	**Route**	**Dose**	**Directions**	**Quantity**	**Refills**
☐Stimate ®	☐NS	☐150 mcg ☐300 mcg		☐1 month ☐3 months	
☐Amicar ®	☐Tablet ☐Syrup	______ mg/kg		☐1 month ☐3 months	
☐ Other:					
Flush	**Route**	**Dose**	**Directions**	**Quantity**	**Refills**
☐ Saline 10mL	☐IV	☐ 3mL ☐ 5 mL ☐______	☐ Before and after infusion ☐______	☐1 month ☐3 months	
☐Heparin 10 units/mL ☐Heparin 100 units/mL	☐IV	☐ 3mL ☐ 5 mL ☐______	☐After infusion ☐______	☐1 month ☐3 months	
Anaphylaxis	**Route**	**Dose**	**Directions**	**Quantity**	**Refills**
☐ Diphenhydramine	☐ IV ☐PO ☐IM	☐ 25 mg ☐ 50 mg ☐______	☐Pre-med: ______ ☐______	☐ w/ ea. Infusion ☐ ______	
☐ Epinephrine	☐ IM ☐ SQ	☐ Adult: 1:1000 0.3 mL ☐ Peds 1:2000 0.3 mL	☐ PRN Anaphylaxis ☐ Repeating Dose: ______	☐ Once ☐ ______	
EpiPen (2 pack)	☐ IM ☐ SQ				

Nursing: ☐ Yes ☐ No Access: ______

SIGNATURE

X______________________________ Date: ______

Prescriber Signature

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