



ORAL TRANSPLANT REFERRAL FORM

TODAY'S DATE _____

CURRENT PATIENT NEW PATIENT

PLEASE FAX REFERRAL FORM TO:

- BiologicTx - NJ**
TEL: 877-567-8087 FAX: 877-567-8089
- BiologicTx - CA**
TEL: 800-404-1963 FAX: 800-404-4595
- BiologicTx - IL**
TEL: 888-892-7607 FAX: 877-567-8089
- Decillion Healthcare**
TEL: 800-622-9321 FAX: 866-548-8849

- Elwyn Specialty Care**
TEL: 855-359-9679 FAX: 610-545-6030
- Factor Support Network**
TEL: 877-376-4968 FAX: 805-482-6324
- Matrix Health**
TEL: 877-337-3002 FAX: 888-385-2805
- Med Center Specialty Pharmacy**
TEL: 855-633-5633 FAX: 304-344-0655
- MedEx BioCare**
TEL: 800-962-6339 FAX: 901-382-3091

Patient Name _____ SS# _____ DOB _____ Male Female
 Street Address _____ Apt# _____ City _____ State _____ Zip _____
 Daytime Tel _____ Cell _____ Email _____ Height _____ Weight _____ BSA _____
 Ship to Patient at Home Work OR Patient will pick up at Physician Office Local Pharmacy Phone _____
 Allergies _____ Comorbidities _____
 Current Medications (if necessary, please fax a complete list) _____

PRACTICE NAME	ADDRESS	PHONE	PRIMARY CONTACT
_____	_____	_____	_____

PRESCRIBER INFORMATION (PLEASE INCLUDE PHYSICIAN NAME AND NPI#)

<input type="checkbox"/>	_____ # _____	<input type="checkbox"/>	_____ # _____	<input type="checkbox"/>	_____ # _____
<input type="checkbox"/>	_____ # _____	<input type="checkbox"/>	_____ # _____	<input type="checkbox"/>	_____ # _____
<input type="checkbox"/>	_____ # _____	<input type="checkbox"/>	_____ # _____	<input type="checkbox"/>	_____ # _____

Insured's Name _____ Relation to Patient _____
 Eligible for Medicare Yes No If yes, Medicare# _____ Prescription Card Yes No If Yes, Carrier _____
 Tel _____ Fax _____ Policy/Group# _____
 Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

- ICD-10 Code Z94.0: Kidney Transplant Status Z94.4: Liver Transplant Status
 Z94.1: Heart Transplant Status Z94.81: Bone Marrow Transplant Status
 Z94.2: Lung Transplant Status Z94.83: Pancreas Transplant Status
 Z94.3: Heart and Lung Transplant Status

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

PREVIOUS THERAPIES

Medication Strength & Dose	Dates of Therapy	Reason for Discontinuing

PHYSICIAN ORDERS

MEDICATION	STRENGTH	DOSE	ROUTE	DIRECTIONS	QTY	REFILLS	DISPENSE BRAND NAME AS WRITTEN (MD MUST INITIAL)

COMMENTS

By signing this form and utilizing our services, you are authorizing BioMatrix Specialty Pharmacy, its subsidiaries and their employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) _____ *Dispense as written* **Date** _____

Prescriber's Signature (signature required. NO STAMPS) _____ *Product Substitution Permitted* **Date** _____

IMPORTANT NOTICE: This message may contain privileged and confidential information and is intended only for the individual named. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document by mistake, then destroy this document. Please direct all verification or notification to BioMatrix Specialty Pharmacy or any of its subsidiaries using the contact information provided on this cover sheet. RF012_v1 07/18

Please visit WWW.BIOMATRIXSPRX.COM For more information