BIOMATRIX SpRx

SUBCUTANEOUS IMMUNE GLOBULIN 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#)

☐_____ #_____	☐_____ #_____	☐_____ #_____
☐_____ #_____	☐_____ #_____	☐_____ #_____
☐_____ #_____	☐_____ #_____	☐_____ #_____

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

- D80.0 Hereditary Hypogammaglobulinemia
- D80.5 Immunodeficiency with Increased immunoglobulin M (IgM)
- D81.0 Severe Combined Immunodeficiency with Reticular Dysgenesis
- D81.1 Immunodeficiency with Low T- and B-Cell Numbers
- D81.2 Severe Combined Immunodeficiency with Low or Normal T- and B-Cell Numbers
- D81.6 Major Histocompatability Complex Class 1 Deficiency
- D81.7 Major Histocompatability Complex Class 2 Deficiency
- D81.89 Other Combined Immunodeficiencies
- D81.9 Combined Immunodeficiency, Unspecified
- D82.0 Wiskott-Aldrich Syndrome
- D83.0 CVID with Predom Abnlt of B-Cells numbers and functions
- D83.2 CVID with Autoantibodies to B- or T-Cells
- D83.8 Other Common Variables
- D83.9 Common Variable Immunodeficiency, Unspecified

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

PHYSICIAN ORDERS – SCIg THERAPY (Pharmacy to provide pump and necessary supplies for administration of SCIg)

Infuse Subcutaneous Immune Globulin _____GMS OR _____ mLs to be infused simultaneously into _____ (#) of subcutaneous sites via pump over _____ hours using SCIg needle sets.
Infusion Frequency: _____ Quantity: _____ # of Refills: _____
Dispense As Written (initial):_____ Brand:_____

PRE-MED ORDERS

Apply topically to skin 30 minutes prior to subcutaneous needle insertion.
☐ Emla 2.5% Cream ☐ LMX -4 Cream ☐ Other Medications:_____
Will dispense generically unless MD specifies brand by initialing Dispense As Written (initial):_____ Brand:_____

ANAPHYLAXIS/FLUSH/SUPPLY ORDERS

Anaphylaxis Kit: ☐ Adult EpiPen 0.3mg/0.3mL Auto-Injector ☐ Pediatric EpiPen Jr. 0.15mg/0.3mL Auto-Injector
Will dispense generically unless MD specifies brand by initialing Dispense As Written (initial):_____ Brand:_____

NURSING ORDERS

- Provide skilled nursing care to instruct administration of SCIg therapy.
- Nurse to complete physical assessment including vital signs with each visit.
- Provide education regarding medication, disease state, adverse drug reactions and procedures, pump and pump care, & administration.
- Observe for response to therapy.
- Patient to be discharged from nursing once independent with therapy administration.

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**_____