



**GENERAL REFERRAL FORM**  
**NOT FOR CONTROLLED SUBSTANCES**

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: \_\_\_\_\_ Diagnosis: \_\_\_\_\_  
 Testing  Yes  No Results \_\_\_\_\_  
 Patient currently on therapy  Yes  No Date of next blood work \_\_\_\_\_

**PRESCRIPTION PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS**

**MEDICATION #1:** \_\_\_\_\_  
 Strength/Dosage: \_\_\_\_\_  
 SIG: \_\_\_\_\_ QTY: \_\_\_\_\_ Refills \_\_\_\_\_

**MEDICATION #2:** \_\_\_\_\_  
 Strength/Dosage: \_\_\_\_\_  
 SIG: \_\_\_\_\_ QTY: \_\_\_\_\_ Refills \_\_\_\_\_

**MEDICATION #3:** \_\_\_\_\_  
 Strength/Dosage: \_\_\_\_\_  
 SIG: \_\_\_\_\_ QTY: \_\_\_\_\_ Refills \_\_\_\_\_

**MEDICATION #4:** \_\_\_\_\_  
 Strength/Dosage: \_\_\_\_\_  
 SIG: \_\_\_\_\_ QTY: \_\_\_\_\_ Refills \_\_\_\_\_

**MEDICATION #5:** \_\_\_\_\_  
 Strength/Dosage: \_\_\_\_\_  
 SIG: \_\_\_\_\_ QTY: \_\_\_\_\_ Refills \_\_\_\_\_

**MEDICATION #6:** \_\_\_\_\_  
 Strength/Dosage: \_\_\_\_\_  
 SIG: \_\_\_\_\_ QTY: \_\_\_\_\_ Refills \_\_\_\_\_

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. RF026\_v1 07/18

Please visit [WWW.BIOMATRIXSPRX.COM](http://WWW.BIOMATRIXSPRX.COM) For more information