ITP REFERRAL FORM *(PAGE 1 OF 2)*

BIOMATRIX SPRX **TEL:** 877-567-8087 **FAX:** 877-567-8089

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 _____ Primary Contact_____ Tel_____
Prescriber _____ NPI #_____
Practice Address _____ Suite# _____ City _____ State _____ Zip _____

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# _____

PMH: ☐ IGA Deficiency ☐ Cardiac Disease ☐ Diabetes ☐ Renal Dysfunction

Statement of Medical Necessity - Primary Diagnosis

☐ **P61.0** Transient Neonatal Thrombocytopenia
☐ **D69.3** Idiopathic Thrombocytopenia Purpura (ITP)
☐ **O36.0990** Maternal care for other Rh isoimmunization, unspecified trimester, not applicable or unspecified
☐ **E83.119** Hemochromatosis, unspecified
Current Gestational Age: _____ EDC: _____

For NAIT:
Has HPA-1a testing been completed? ☐ Yes ☐ No
Results confirm NAIT? ☐ Yes ☐ No

For ITP:
Current Platelet Count: _____
Gravida: _____ Para: _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

Is this the first dose? ☐ Yes ☐ No
If no: List product_____ Date of last infusion_____ Next dose due_____

PHYSICIAN ORDERS

☐ IVIG Therapy: Infuse IVIG _____ GMS or _____ gm/kg IV over _____ hours or as tolerated.
If not specified, will follow company policy for IVIG administration.
Frequency: _____ QTY/# of Refills: _____
☐ Pharmacy to select Product ☐ Specific Brand desired, please specify: _____
☐ Other Therapy: Infuse _____ Dose_____ Frequency _____
Route of Administration: _____ Infusion Rate: _____ QTY/# of Refills: _____
☐ Pharmacy to select Product ☐ Specific Brand desired, please specify: _____
Provide all necessary ancillary supplies (i.e. pole, pump, etc.) as required for therapy and diagnosis

PRE-MEDICATIONS Pre-Medicate 30 minutes prior.

☐ Diphenhydramine (Benadryl) _____ mg orally
☐ Acetaminophen (Tylenol) _____ mg
☐ Prednisone (Cortisone) _____ mg orally
☐ Other _____

ANAPHYLAXIS/FLUSH/SUPPLY ORDERS Equipment (pole, pump)/Supplies will be provided as per therapy requirements.

Anaphylaxis Kit: ☐ Adult ☐ Pediatric

Adults or Children greater than 66 pounds or 30kg

- For mild reaction: give Diphenhydramine 50mg orally, IM , or IV and decrease the rate of infusion
- For moderate reaction: stop infusion, give Diphenhydramine 50mg, orally, IM or IV and contact physician
- For severe reaction with breathing problem: stop infusion, call 911, give Epinephrine 0.3mg/0.3ml subcutaneously, Diphenhydramine 50mg IV or IM and contact physician

*Note: **Dosage adjustment necessary for children less than 30 kg or 66 pounds**: Diphenhydramine 1.25mg/kg orally, IM or IV with a maximum of 50mg.*

If Epinephrine is needed 0.15mg/0.15ml subcutaneously

Flush Orders (PRN Catheter Maintenance):
☐ Saline 0.9% Flush 5ml or D5W (determined by IVIG compatibility)
☐ Heparin Flush 10 units/ml - 5ml
☐ Heparin Flush 100 units/ml - 5ml

COMPLETE PAGE 2 WITH CLINICAL INFORMATION

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LAB WORK ORDERS

☐ Lab Orders: _____

☐ Frequency of Lab Work: _____

NURSING ORDERS

☐ Provide skilled nursing care to complete therapy.

☐ Baseline Vital Signs: BP, HR, Temp prior to infusion, every 15 minutes x 1st hour and each subsequent hour until completion.

☐ Provide education regarding medication, disease state, adverse drug reactions, and administration.

☐ Observe for response to therapy.

☐ IV Access: _____ Location: _____

☐ Maintain IV Access according to company policy and procedures.
Hold Infusion If: _____ BP systolic above 180 mm Hg or _____ BP diastolic above 105 mm Hg

PLEASE INCLUDE THE FOLLOWING

☐ MD Prescription

☐ Most recent lab results (attach copy of results)

☐ Complete Patient History, reconciled medication list, and most recent clinical visit notes

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 where allowed by law or contract.

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

Prescriber's Email_____