LMW HEPARIN / HEPARIN REFERRAL FORM

BIOMATRIX SPRX **TEL:** 855-359-9679 **FAX:** 610-545-6030

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: _____ Diagnosis: _____
Testing? ☐ Yes ☐ No Results _____
Duration of treatment: From _____ To _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

FRAGMIN (Dalteparin)

☐ 2,500 units/0.2ml	Syringe: _____	SIG: _____	QTY: _____	Refills: _____
☐ 5,000 units/0.2ml	Syringe: _____	SIG: _____	QTY: _____	Refills: _____
☐ 7,500 units/0.3ml	Syringe: _____	SIG: _____	QTY: _____	Refills: _____
☐ 10,000 units/1ml	Syringe: _____	SIG: _____	QTY: _____	Refills: _____
☐ 12,500 units/0.5ml	Syringe: _____	SIG: _____	QTY: _____	Refills: _____
☐ 15,000 units/0.6ml	Syringe: _____	SIG: _____	QTY: _____	Refills: _____
☐ 18,000 units/0.72ml	Syringe: _____	SIG: _____	QTY: _____	Refills: _____

LOVENOX (Enoxaprin)

☐ 30 mg/0.3ml	Syringe: _____	SIG: _____	QTY: _____	Refills: _____
☐ 40 mg/0.4ml	Syringe: _____	SIG: _____	QTY: _____	Refills: _____
☐ 60 mg/0.6ml	Syringe: _____	SIG: _____	QTY: _____	Refills: _____
☐ 80 mg/0.8ml	Syringe: _____	SIG: _____	QTY: _____	Refills: _____
☐ 100 mg/1ml	Syringe: _____	SIG: _____	QTY: _____	Refills: _____
☐ 120 mg/0.8ml	Syringe: _____	SIG: _____	QTY: _____	Refills: _____
☐ 150 mg/1ml	Syringe: _____	SIG: _____	QTY: _____	Refills: _____

ARIXTRA (Fondaparinux)

☐ 2.5 mg/0.5ml	Vial: _____	SIG: _____	QTY: _____	Refills: _____
☐ 5 mg/0.4ml	Vial: _____	SIG: _____	QTY: _____	Refills: _____
☐ 7.5 mg/0.6ml	Vial: _____	SIG: _____	QTY: _____	Refills: _____
☐ 10 mg/0.8ml	Vial: _____	SIG: _____	QTY: _____	Refills: _____

☐ **HEPARIN SODIUM** 5,000 units/0.5ml
Vial: _____ SIG: _____ QTY: _____ Refills: _____

☐ **OTHER** _____	SIG: _____	QTY: _____	Refills: _____
☐ **OTHER** _____	SIG: _____	QTY: _____	Refills: _____
☐ **OTHER** _____	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 where allowed by law or contract.

Prescriber's Signature _____ *(Signature required. NO STAMPS)* **AND** *Hand write: brand medically necessary, if needed* **Date**_____

Prescriber's Email_____