



Enbrel, IVIG, Raptiva or Amevive Referral Form

BIOMED Pharmaceuticals

Phone: (817) 923-4495

Toll Free: (866) 923-4495

Intake Fax: (866) 923-4492

Corporate Office
1512 8th Ave. Suite 100
Fort Worth, TX 76104

Desoto
2727 Bolton Boone Dr. Ste 110
Desoto, TX 75115

Houston
1919 N. Loop West, Ste 180
Houston, TX 77008

Tyler
837 S. Fleishel
Tyler, TX 75701

San Antonio
211 North San Saba, Suite 205
San Antonio, TX 78207

Name: _____ Date of Birth: _____ Allergies: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Male Female

Primary Insurance: _____

Secondary Insurance: _____

Phone #: _____

Phone#: _____

Subscriber: _____ DOB: _____

Subscriber: _____ DOB: _____

ID#: _____ Policy/Group#: _____

ID#: _____ Policy/Group#: _____

Prescription Drug Card _____ Number _____

Statement of Medical Necessity

Diagnosis:

- ___ Pemphigus Vulgaris (694.4)
- ___ Pemphigus Foliaceus (694.4)
- ___ Bullous Pemphigoid (694.5)
- ___ Other (specify ICD-9) _____

- ___ Epidermolysis Bullosa Acquisita (694.8)
- ___ Psoriasis (690.0)
- ___ Dermatomyositis (710.3)
- ___ Mucous Membrane Pemphigoid (694.60) with ocular involvement (694.61)
- ___ Atopic Dermatitis (691.8)

Weight _____(lbs) _____(kg)

Allergies: _____

Medications: ___NO ___YES (please explain) _____

Prescription: good for one year unless otherwise specified under special instructions.

___ IVIG _____ Dosage _____ Frequency (given IV at AAIC infusion center) _____ Brand desired, if available.

___ Enbrel 25mg and Sterile Water for injection and related supplies (given SQ) _____ Frequency

___ Enbrel 50mg pre-filled syringe (given SQ) _____ Frequency

___ Amevive _____ Dosage _____ Frequency _____ Sterile Water for injection (given IM at AAIC infusion center)

___ Raptiva _____ (0.7mg/kg) conditioning Dose SQ and then begin _____ (1mg/kg) SQ weekly 1 wk after conditioning dose.

Injection Training at Physician's Office _____ TB test

Special Instructions _____

Physician Certification: I certify the above therapy is medically necessary for 1 year, and the information is accurate to the best of my knowledge.

Signature: _____ Date _____ NPI# _____

Print Name: _____ DEA# _____

Address: _____ City: _____ St _____ Zip _____

Phone: _____ Fax: _____ **Thank you for your referral.**



Please send front and back copy of all insurance cards with referral.