US Bioservices
AmerisourceBergen

Maternal-Fetal Medicine Referral Form

Phone: (877) 674-9700
Fax: (877) 402-4042

Deliver to: ☐ Patient's Home ☐ Prescriber's Office ☐ Other: _____ ☐ Hold shipment until notified by prescriber ☐ Anticipated Start Date: _____

1. Patient Information

Last Name: _____ Home Phone: _____ Work / Mobile Phone: _____

First Name: _____ Home Address: _____

S.S. #: _____ Date of Birth: _____ City: _____ State: _____ Zip: _____

Guardian / Caregiver: _____ Sex: ☐ Male ☐ Female Height: _____ Weight: _____ ☐ lb ☐ kg

2. Patient Insurance Information (Please fax front and back copy of all insurance cards - prescription and medical)

Medical Insurance: _____ Phone: _____ Prescription Card: _____ Phone: _____

Subscriber Name: _____ Policy #: _____ BIN / PCN: _____

Policy #: _____ Group #: _____ Medicare #: _____ Medicaid #: _____

3. Prescriber Information

Prescriber Name: _____ ☐ MD ☐ DO ☐ NP ☐ PA License #: _____ NPI #: _____ DEA #: _____

Practice Name: _____ Phone: _____ Fax: _____

Address: _____ Office Contact: _____ Phone: _____

City: _____ State: _____ Zip: _____ Collaborating Physician: _____

4. Diagnosis and Clinical Information (Please fax recent clinical notes, labs and tests, with the prescription to expedite the prior authorization)

☐ D69.0 Allergic Purpura ☐ E83.110 Neonatal Hemochromatosis ☐ P61.0 Transient Neonatal Thrombocytopenia (NAIT)

☐ D69.3 Immune Thrombocytopenic Purpura (ITP) ☐ O36.0110 Rh Sensitization or Severe Isoimmunization ☐ Other: _____

Medical History:

☐ Renal insufficiency ☐ Thromboembolic event ☐ CHF ☐ Diabetes ☐ HTN ☐ Other: _____

Patient recieved IVIG previously? ☐ Yes ☐ No Lab Orders: _____

Allergies: _____ Concurrent Medications: _____

Current Gestational Age: _____ EDC: _____

Gravida: _____ Para: _____

For NAIT:

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

For ITP:

Platelet Count: _____ Date: _____

5. Prescription Information

Brand	Therapy Regimen	Refills
1.	Dose: _____ g/day x _____ days, every _____ weeks	
2.	Dose: _____ g/kg/day x _____ days, every _____ weeks	

Pre-Meds:

☐ Tylenol® 500-1000 mg PO PRN

☐ Benadryl® 25-50 mg PO PRN

☐ IV Steroids: _____

☐ IV Hydration: _____

☐ Other: _____

☐ Anaphylaxis Kit: • Epinephrine IM/SC 1:1000-0.3 mg UD PRN anaphylaxis reaction
• Diphenhydramine IV 50 mg/ml UD PRN anaphylaxis reaction
• NS IV 500 mL UD PRN anaphylaxis reaction

☐ Include 0.9 NaCl, Heparin 10-100 units/ml, and / or D5W flushes PRN to establish and maintain IV access

☐ Ramp infusion as directed by manufacturer as tolerated by patient

☐ Provide nurse for infusion of medication(s) ordered

Patient Support Programs: Please have patient sign and date to enroll in pharmaceutical company assisted patient support program.

Patient Signature _____ Date ____ / ____ / ____

Account Manager

_____

Prescriber Authorization (No stamps. Signature and date must be completed in prescriber's handwriting. NY prescriptions must be submitted via e-script.)

I authorize US Bioservices Corporation to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans.

Prescriber Signature-Substitution Permissible _____ PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. Date ____ / ____ / ____

Prescriber Signature-Dispense as Written _____ PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. Date ____ / ____ / ____