



Procrit and Neupogen Program Referral

BIOMED Pharmaceuticals

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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: _____ SS#: _____

Address: _____ City: _____ St. _____ Zip _____

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

Weight: _____ Allergies: _____ Primary Language _____

Emergency Contact Name _____ Relationship _____ Phone _____

Prescription Drug Card: Name _____ Group# _____ ID# _____

Primary Insurance: _____ Secondary Insurance: _____

Phone #: _____ Subscriber: _____ Phone #: _____ Subscriber: _____

DOB: _____ ID#: _____ Policy/Group #: _____ DOB: _____ ID#: _____ Policy/Group #: _____

Employer: _____ Employer: _____

Diagnosis: ___ Code _____ Description _____

NEUPOGEN

___ 150 ug ___ 300 ug ___ 480 ug
___ q week ___ BIW Refills x _____ Months

Supplies:

___ 1 ml syringe # _____ Refills _____
___ 3 ml syringe # _____ Refills _____
___ 25 g 5/8" needle # _____ Refills _____
___ 27 g 1/2" needle # _____ Refills _____
___ Other: _____ # _____ Refills _____
___ Other: _____ # _____ Refills _____

PROCRIT

___ 10,000 IU ___ 20,000 IU ___ 40,000 IU

Refills x _____ Months Sig: _____

Supplies:

___ 1 ml syringe # _____ Refills _____
___ 3 ml syringe # _____ Refills _____
___ 25 g 5/8" needle # _____ Refills _____
___ 27 g 1/2" needle # _____ Refills _____
___ Other: _____ # _____ Refills _____
___ Other: _____ # _____ Refills _____

OTHER: _____

Refills x _____ Months

Patient Status-to be filled out by pharmacy

No contact as of: _____ PA required: ___yes ___no Ship Date: _____

Generic can be substituted where available ___Yes ___No

Physician Certification: Anticipated Start Date: _____ Today's Date _____ DEA # _____ NPI# _____

Signature: _____ Print Name: _____

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

Phone: _____ Fax: _____ TPI # _____ UPIN# _____ Tax ID# _____



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