

Hemophilia & Bleeding Disorders

- Orange, CA
- Las Vegas, NV
- Allen, TX
- Memphis, TN

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 P: (469) 257-4200
 P: (901) 560-3580

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 F: (702) 790-4406
 F: (469) 795-9204
 F: (901) 560-3581



PATIENT INFORMATION (Please complete the following or fax the patient demographic sheet)

Patient Name _____ DOB _____ Last Four of SS# _____ Sex: Male Female
 Address _____ City, State, ZIP _____
 Main Phone _____ Alternate Phone _____ Language Preference: English Spanish Other _____

PRESCRIBER INFORMATION

Prescriber's Name _____ Address _____
 NPI _____ DEA _____ Lic _____ City, State, ZIP _____
 Contact Person _____ Group/Hospital _____ Phone _____ Fax _____

INSURANCE INFORMATION (Please fax a copy of patient's insurance card- both sides)

Prior Authorization Reference number _____

CLINICAL INFORMATION

Diagnosis – Please include diagnosis name with ICD-10 code
 D66 Hereditary factor VIII deficiency D67 Hereditary factor IX deficiency
 D68.0 Von Willebrand Disease----- Type 1 Type 2 Type 3
 Other: ICD-10 Code _____ Description _____
Date of Diagnosis _____
Next Infusion Date _____ Target Joints: No Yes _____
Infusion by*: Parent Patient Other _____
Access: Peripheral PICC PORT Other _____

Therapy: New Reauthorization Restart
 Weight: _____ kg / lb (circle) Height: _____ cm / in (circle)
 Allergies: NKDA Other _____
 Historical response: High Low Date: _____
 Factor Deficiency: Severe (<1%) Moderate (1-5%) Mild (>5%)
 Circulating Factor: _____ % Inhibitor: Low Historical Current
 Comorbidities: _____
 Concomitant medications: _____
 *Skilled nursing visits provided as needed

PRESCRIPTION INFORMATION (Ancillary supplies provided as needed for administration)

Medication	Dose & Directions (Dose to be +/-10% unless specified)	Quantity	Refills
Factor VIII (Recombinant) <input type="checkbox"/> Advate® <input type="checkbox"/> Eloctate® <input type="checkbox"/> Kogenate FS® <input type="checkbox"/> Nuwiq® <input type="checkbox"/> Adynovate® <input type="checkbox"/> Esperoct® <input type="checkbox"/> Kovaltry® <input type="checkbox"/> Recombinate® <input type="checkbox"/> Afstyla® <input type="checkbox"/> Jivi® <input type="checkbox"/> Novoeight® <input type="checkbox"/> Xyntha®	Assay Variation: +/- _____%		
Factor VIII (Human) <input type="checkbox"/> Hemofil M® <input type="checkbox"/> Koate®	<input type="checkbox"/> Prophylaxis: _____	_____ Doses/month	_____
Factor VIII and VWF **Dose will be dispensed in vWF:RCo units unless specified otherwise <input type="checkbox"/> Alphanate® <input type="checkbox"/> Humate P®** <input type="checkbox"/> Vonvendi®** <input type="checkbox"/> Wilate®**	<input type="checkbox"/> Immune Tolerance: _____	_____ Doses/month	_____
Factor IX <input type="checkbox"/> AlphaNine® SD <input type="checkbox"/> Benefix® <input type="checkbox"/> Ixinity® <input type="checkbox"/> Rebinyn® <input type="checkbox"/> Alprolix® <input type="checkbox"/> Idelvion® <input type="checkbox"/> Mononine® <input type="checkbox"/> Rixubis®	<input type="checkbox"/> Breakthrough Bleeding: <input type="checkbox"/> Minor: _____ <input type="checkbox"/> Moderate: _____ <input type="checkbox"/> Major: _____	_____ Doses/month _____ Doses/month _____ Doses/month	_____
Factor XIII <input type="checkbox"/> Corifact® <input type="checkbox"/> Tretten®	<input type="checkbox"/> Other: _____	_____ Doses/month	_____
Inhibitor Therapies, Factor VIIa, and other <input type="checkbox"/> Feiba® <input type="checkbox"/> NovoSeven® <input type="checkbox"/> Other: _____			
Hemlibra® <input type="checkbox"/> 30mg/mL <input type="checkbox"/> 60mg/0.4mL <input type="checkbox"/> 105mg/0.7mL <input type="checkbox"/> 150mg/mL	<input type="checkbox"/> Initial dose: 3mg/kg subQ once weekly for 4 weeks <input type="checkbox"/> Maintenance dose: 1.5mg/kg subQ once weekly <input type="checkbox"/> Maintenance dose: 3mg/kg subQ every 2 weeks <input type="checkbox"/> Maintenance dose: 6mg/kg subQ every 4 weeks <input type="checkbox"/> Other: _____		
<input type="checkbox"/> EMLA® Cream, 30gm <input type="checkbox"/> Other: _____			
<input type="checkbox"/> EPIPEN® 0.3mg <input type="checkbox"/> EPIPEN Jr® 0.15mg	<input type="checkbox"/> Inject as needed for anaphylaxis		
Stimate® <input type="checkbox"/> 150mcg/actuation nasal spray	<input type="checkbox"/> Wt<50kg, single spray in one nostril (1 spray total) <input type="checkbox"/> Wt>50kg, single spray in each nostril (2 sprays total)		
Amicar® <input type="checkbox"/> 500mg tablets <input type="checkbox"/> 25% Oral Solution			
Lysteda® <input type="checkbox"/> 650mg tablets			
Flushing <input type="checkbox"/> 0.9% Normal Saline Flush, 5-10mL pre and post IV medication administration <input type="checkbox"/> Heparin 10units/mL Flush, 3-5mLs as needed <input type="checkbox"/> Heparin 100units/mL Flush, 1-3mLs as needed		<input type="checkbox"/> Quantity Sufficient <input type="checkbox"/> PRN <input type="checkbox"/> _____ <input type="checkbox"/> _____	

*Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Deliver to: Patient Office Other _____ Needs by Date: _____

Prescriber's Signature _____ Date _____ Substitution permitted unless this box is checked

CONFIDENTIALITY STATEMENT: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone.