InfuCare Rx

Hemophilia & Bleeding Disorders Referral Form

of Pages Faxed:__________
Fax Referral To: 877-828-3941
Phone: 877-828-3940

Date Required:__________ Ship To: ☐ Home ☐ Office ☐ Other:__________

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name:	Prescriber Name:
Address:	Address:
City, State, Zip:	City, State, Zip:
Home Phone:	Phone:
Cell Phone:	Fax:
Alternate Phone:	DEA #: NPI #:
Date of Birth:	Contact Person:

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: __________ ID: __________ Group: __________
Secondary Insurance: __________ ID: __________ Group: __________
Prescription Card: __________ ID: __________ BIN: __________ PCN: __________

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

DIAGNOSIS

- ☐ D66 Hemophilia A (Factor VIII deficiency)
- ☐ D67 Hemophilia B (Factor IX deficiency)
- ☐ D68.1 Hemophilia C (Factor XI deficiency)
- ☐ D68.2 Hereditary Deficiency of other clotting factors
- ☐ 68.0 von Willebrand Disease
- ☐ D69.9 Hemorrhagic Condition, Unspecified
- ☐ D68.4 Acquired Coagulation Factor Deficiency
- ☐ D68.8 Other Specified Coagulation Defects
- ☐ Other:__________

PATIENT EVALUATION

Therapy: ☐ New ☐ Reauthorization ☐ Restart
Patient Weight:_____ ☐ kg ☐ lbs Height:_____ ☐ cm ☐ in
Allergies:__________
Circulating Factor:____ % Inhibitor: ☐ No ☐ Historical ☐ Current
Historical Response: ☐ High ☐ Low Date:__________
Concomitant Medications:__________
Factor Deficiency: ☐ Severe (<1%) ☐ Moderate (1-5%) ☐ Mild (>5%)
Line Access: ☐ Port ☐ PICC ☐ PIV ☐ Butterfly ☐ Other:__________
Nursing Coordination:
☐ Pharmacy to coordinate home health nursing visit as necessary: ☐ Yes ☐ No
☐ Home health nursing coordination not necessary. Reason:
☐ MD office to administer to patient
☐ Home health nursing already coordinated

PRESCRIPTION INFORMATION

Medication:

Factor VIII (Recombinant)
- ☐ Advate®
- ☐ Adynovate®
- ☐ Afstyla®
- ☐ Eloctate®
- ☐ Helixate® FS
- ☐ Kogenate® FS
- ☐ Kovaltry®
- ☐ NovoEight®
- ☐ Nuwiq®
- ☐ Recombinate®
- ☐ Xyntha®

Factor VIII (Monoclonal)
- ☐ Hemofil M®
- ☐ Monoclate®

P **Factor VIII (Other)**
- ☐ Alphanate® SDHT
- ☐ Humate P®
- ☐ Koate® DVI
- ☐ Wilate®

Factor IX
- ☐ AlphaNine® SDVF
- ☐ Alprolix®
- ☐ Bebulin® VH
- ☐ Benefix®
- ☐ IDELVION®
- ☐ Ixinity®
- ☐ Mononine®
- ☐ Profilnine® SD
- ☐ Rixubis®

Factor XIII
- ☐ Corifact®
- ☐ Tretten®

Inhibitor Therapies
- ☐ Feiba® VH
- ☐ NovoSeven®

Dose/Strength:

Directions:

☐ Prophylaxis:
Infuse ____ units (+/-10%)
slow iv-push every ________

☐ Breakthrough Bleed:
Infuse ____ units (+/-10%)
slow iv-push every ________
☐ hours ☐ days
for a total of ____ doses
as needed for bleeding episodes

Minor: ☐ ____ IU every ☐ hour ☐ day PRN
Major: ☐ ____ IU every ☐ hour ☐ day PRN
☐ Other:__________

Quantity:

Refills:

PREMEDICATION ORDERS/OTHER MEDICATIONS

Flush Protocol
- ☐ NaCl 0.9% 5ml
- ☐ NaCl 0.9% 10ml
- ☐ Heparin 10 units/ml
- ☐ Heparin 100 units/ml
- ☐ Amicar Tablet / Syrup Quantity:______ Refill:______
- ☐ Directions:__________

STAMP SIGNATURE NOT ALLOWED

PHYSICIAN SIGNATURE REQUIRED

Prescriber Signature:__________ **Date:**__________

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