

Date Required: _____ Ship To: Home Office Other: _____

PATIENT INFORMATION

Patient Name: _____
 Address: _____
 City, State, Zip: _____
 Home Phone: _____
 Cell Phone: _____
 Alternate Phone: _____
 Date of Birth: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
 Address: _____
 City, State, Zip: _____
 Phone: _____
 Fax: _____
 DEA #: _____ NPI #: _____
 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:	Dose/Strength:	Directions:	Quantity:			
<table style="width: 100%;"> <tr> <td style="width: 33%; vertical-align: top;"> Factor VIII (Recombinant) <input type="checkbox"/> Advate® <input type="checkbox"/> Adynovate® <input type="checkbox"/> Afstyla® <input type="checkbox"/> Eloctate® <input type="checkbox"/> Helixate® FS <input type="checkbox"/> Kogenate® FS <input type="checkbox"/> Kovaltry® <input type="checkbox"/> NovoEight® <input type="checkbox"/> Nuwiq® <input type="checkbox"/> Recombinate® <input type="checkbox"/> Xyntha® </td> <td style="width: 33%; vertical-align: top;"> Factor VIII (Monoclonal) <input type="checkbox"/> Hemofil M® <input type="checkbox"/> Monoclate® P Factor VIII (Other) <input type="checkbox"/> Alphanate® SDHT <input type="checkbox"/> Humate P® <input type="checkbox"/> Koate® DVI <input type="checkbox"/> Wilate® Factor IX <input type="checkbox"/> AlphaNine® SDVF <input type="checkbox"/> Alprolix® <input type="checkbox"/> Bebulin® VH </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Benefix® <input type="checkbox"/> IDELVION® <input type="checkbox"/> Ixinity® <input type="checkbox"/> Mononine® <input type="checkbox"/> Profilnine® SD <input type="checkbox"/> Rixubis® Factor XIII <input type="checkbox"/> Corifact® <input type="checkbox"/> Tretten® Inhibitor Therapies <input type="checkbox"/> Feiba® VH <input type="checkbox"/> NovoSeven® </td> </tr> </table>	Factor VIII (Recombinant) <input type="checkbox"/> Advate® <input type="checkbox"/> Adynovate® <input type="checkbox"/> Afstyla® <input type="checkbox"/> Eloctate® <input type="checkbox"/> Helixate® FS <input type="checkbox"/> Kogenate® FS <input type="checkbox"/> Kovaltry® <input type="checkbox"/> NovoEight® <input type="checkbox"/> Nuwiq® <input type="checkbox"/> Recombinate® <input type="checkbox"/> Xyntha®	Factor VIII (Monoclonal) <input type="checkbox"/> Hemofil M® <input type="checkbox"/> Monoclate® P Factor VIII (Other) <input type="checkbox"/> Alphanate® SDHT <input type="checkbox"/> Humate P® <input type="checkbox"/> Koate® DVI <input type="checkbox"/> Wilate® Factor IX <input type="checkbox"/> AlphaNine® SDVF <input type="checkbox"/> Alprolix® <input type="checkbox"/> Bebulin® VH	<input type="checkbox"/> Benefix® <input type="checkbox"/> IDELVION® <input type="checkbox"/> Ixinity® <input type="checkbox"/> Mononine® <input type="checkbox"/> Profilnine® SD <input type="checkbox"/> Rixubis® Factor XIII <input type="checkbox"/> Corifact® <input type="checkbox"/> Tretten® Inhibitor Therapies <input type="checkbox"/> Feiba® VH <input type="checkbox"/> NovoSeven®		<input type="checkbox"/> Prophylaxis: Infuse _____ units (+/-10%) slow iv-push every _____ <input type="checkbox"/> Breakthrough Bleed: Infuse _____ units (+/-10%) slow iv-push every _____ <input type="checkbox"/> hours <input type="checkbox"/> days for a total of _____ doses as needed for bleeding episodes Minor: <input type="checkbox"/> _____ IU every <input type="checkbox"/> hour <input type="checkbox"/> day PRN Major: <input type="checkbox"/> _____ IU every <input type="checkbox"/> hour <input type="checkbox"/> day PRN <input type="checkbox"/> Other: _____	Refills: _____
Factor VIII (Recombinant) <input type="checkbox"/> Advate® <input type="checkbox"/> Adynovate® <input type="checkbox"/> Afstyla® <input type="checkbox"/> Eloctate® <input type="checkbox"/> Helixate® FS <input type="checkbox"/> Kogenate® FS <input type="checkbox"/> Kovaltry® <input type="checkbox"/> NovoEight® <input type="checkbox"/> Nuwiq® <input type="checkbox"/> Recombinate® <input type="checkbox"/> Xyntha®	Factor VIII (Monoclonal) <input type="checkbox"/> Hemofil M® <input type="checkbox"/> Monoclate® P Factor VIII (Other) <input type="checkbox"/> Alphanate® SDHT <input type="checkbox"/> Humate P® <input type="checkbox"/> Koate® DVI <input type="checkbox"/> Wilate® Factor IX <input type="checkbox"/> AlphaNine® SDVF <input type="checkbox"/> Alprolix® <input type="checkbox"/> Bebulin® VH	<input type="checkbox"/> Benefix® <input type="checkbox"/> IDELVION® <input type="checkbox"/> Ixinity® <input type="checkbox"/> Mononine® <input type="checkbox"/> Profilnine® SD <input type="checkbox"/> Rixubis® Factor XIII <input type="checkbox"/> Corifact® <input type="checkbox"/> Tretten® Inhibitor Therapies <input type="checkbox"/> Feiba® VH <input type="checkbox"/> NovoSeven®				

PREMEDICATION ORDERS/OTHER MEDICATIONS

Flush Protocol

NaCl 0.9% 5ml Heparin 10 units/ml Amicar Tablet / Syrup Quantity: _____ Refill: _____
 NaCl 0.9% 10ml Heparin 100 units/ml Directions: _____

STAMP SIGNATURE NOT ALLOWED

PHYSICIAN SIGNATURE REQUIRED

Prescriber Signature: _____ Date: _____

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