Hemophilia Enrollment Form

InfuCare Rx

Phone: (844) 773-6779
Fax: (844) 533-1131
Website: www.InfuCareRx.com

PATIENT INFORMATION

Name:			
Address:			
City:	State/Zip:		
Telephone:	DOB:	M ☐ F ☐	
Language Preference:	Wt:	Ht:	

PRESCRIBER INFORMATION

Prescribing Practitioner:		NPI:	
Address:			
City:		State/Zip:	
Office:		DEA:	
Contact:	Phone:	Fax:	

PLEASE FAX COPY OF: ☐ PRESCRIPTION FRONT & BACK ☐ CLINICAL NOTES ☐ MEDICAL CARD FRONT & BACK

PRIMARY INSURANCE INFORMATION

Member Name:		M ☐ F ☐	DOB:
Address:	City:		
State:	Zip:	Telephone:	Alt. Telephone:
Member ID:	Rx Group #:	BIN#:	
PCN#:	Customer Service #:	Please attach a copy of the front and back of the patient's insurance card, if available.*****	

PRESCRIPTION

☐New ☐Refill | Ship by: | Venous Access: ☐Peripheral IV ☐Port-a-Cath ☐PICC ☐Central Line ☐Other:_____

Drug	Strength	Directions	Quantity	Refills
☐ Advate®				
☐ Alphanate®				
☐ Alprolix®				
☐ Amicar®				
☐ Eloctate®				
☐ EMLA® cream		®		
☐ Hemofil-M®				
☐ Humate P®				
☐ Ixinity®				
☐ Jivi®				
☐ Kovaltry®				
☐ Kogenate FS®				
☐ LMX-4® cream				
☐ Mononine®				
☐ Novoeight®				
☐ Novoseven®				
☐ Nuwiq®				
☐ Heparin®	☐ 10units/ml 5ml			
☐ Heparin®	☐ 100units/ml 5ml			
☐ Sodium Chloride®	☐ 0.9% 5ml-10ml			
☐ Other				

DIAGNOSIS AND CLINICAL INFORMATION

***PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY

☐D66 Hemophilia A (Factor VIII Deficiency) ☐D67 Hemophilia B (Factor IX Deficiency) ☐D68.0 von Willebrand's Disease

☐Other: _____

Allergies:

Additional Info:

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing FOSRX/FAST to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies and co-pay foundations.

Prescribing Practitioner Signature: | **Date:**