InfuCare Rx

Hemophilia & Bleeding Disorders Referral Form

of Pages Faxed:_____
Fax Referral To: 844-533-1131
Phone: 844-773-6779

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:_____
Injection Training/Home Health RN visit is necessary. ☐ Yes ☐ No
Site of Care: ☐ Home ☐ MD Office ☐ Other:_____

PRESCRIPTION INFORMATION

Medication:	Dose/Strength:	Directions:	Quantity:	Refills:
Factor VIII (IV) ☐ Advate® ☐ Adynovate® ☐ Afstyla® ☐ Alphanate® SDHT ☐ Eloctate® ☐ Jivi® ☐ Helixate® FS ☐ Hemofil M® ☐ Humate P® ☐ Kogenate® FS ☐ Kovaltry® ☐ NovoEight® ☐ Nuwiq® ☐ Recombinate® ☐ Wilate® ☐ Xyntha® **Factor IX (IV)** ☐ AlphaNine® SDVF ☐ Alprolix® ☐ Benefix® ☐ IDELVION® ☐ Ixinity® ☐ Rixubis® **Inhibitor Therapies** ☐ Feiba® VH ☐ NovoSeven®		☐ Prophylaxis: Infuse ____ units (+/-__ %) slow iv-push every _____ ☐ Breakthrough Bleed: Infuse ____ units (+/-__%) 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:_____		
Subcutaneous ☐ Hemlibra®		☐ Inject ___mg subcutaneously every ____ weeks		
☐ Other:				

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:_____
☐ EMLA® cream ☐ LMX-4® cream

STAMP SIGNATURE NOT ALLOWED

PHYSICIAN SIGNATURE REQUIRED

Prescriber Signature:_____ **Date:**_____