InfuCare Rx

Hemophilia & Bleeding Disorders Enrollment Form

Fax Referral To: 844-533-1131
Phone: 844-773-6779

Please cut along the dotted lines before submitting to a pharmacy.

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:
Date of Birth: ______ Gender: ______	DEA #: ______ NPI #: ______
Emergency Contact: ______ Phone: ______	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: ______ Group: ______

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
- ☐ D68.0 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 SUBQ every ____ weeks		
☐ Other:				

PREMEDICATION ORDERS/OTHER MEDICATIONS

Flush Protocol:

☐ NaCl 0.9% 5ml ☐ Heparin 10 units per ml ☐ Amicar Tablet / Syrup Quantity: ______ Refill: ______ ☐ EMLA® cream
☐ NaCl 0.9% 10ml ☐ Heparin 100 units per ml ☐ Directions: ______________ ☐ LMX-4® cream

STAMP SIGNATURE NOT ALLOWED

PHYSICIAN SIGNATURE REQUIRED

Prescriber Signature: ______________ Date: ______________

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