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

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Date of Birth: _____ Gender: _____
Emergency Contact: _____ Phone: _____

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
☐ 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 ☐ Altuviiio® ☐ 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: ☐ _____ units every ☐ hour ☐ day PRN Major: ☐ _____ units every ☐ hour ☐ day PRN ☐ Other: _____		
Subcutaneous: ☐ Hemlibra®		☐ Inject ___mg SUBQ every ____ weeks		
☐ Other:				

PREMEDICATION ORDERS/OTHER MEDICATIONS

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

STAMP SIGNATURE NOT ALLOWED

PHYSICIAN SIGNATURE REQUIRED

Prescriber Signature: _____ **Date:** _____

✂

Revised 09 Feb 2024