

 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: _____		BIN: _____		PCN: _____
To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:				
DIAGNOSIS		PATIENT EVALUATION		
☐ 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: _____		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® ☐ Afstyl® ☐ Alphanate® ☐ Altuviiio® ☐ Elocate® ☐ Jivi® ☐ Hemofil M® ☐ Humate P® ☐ Kovaltry® ☐ NovoEight® ☐ Nuwiq® ☐ Recombinate®	☐ Wilate® ☐ Xyntha® Factor IX (IV): ☐ AlphaNine® ☐ Alprolix® ☐ Benefix® ☐ Idelvion® ☐ Ixinity® ☐ Rixubis® Bypassing/Other: ☐ Feiba® ☐ NovoSeven® ☐ Riastap® ☐ Sevenfact®	☐ Prophylaxis: Infuse _____ units (+/- _____ %) slow iv-push every _____ ☐ Breakthrough Bleed: Infuse _____ units (+/- _____ %) slow iv-push every _____ days ☐ weeks for a total of _____ doses as needed for bleeding episodes Minor: ☐ _____ units every ☐ hour ☐ day PRN Major: ☐ _____ units every ☐ hour ☐ day PRN ☐ Other: _____		
Subcutaneous: ☐ Alhemo® ☐ Hemlibra® ☐ Hymapvzi® ☐ Other: _____		☐ Inject _____ mg SUBQ every _____ ☐ Days ☐ Weeks		
PREMEDICATION ORDERS/OTHER MEDICATIONS				
Flush Protocol:				
☐ NaCl 0.9% 5ml ☐ Heparin 10 units per ml ☐ NaCl 0.9% 10ml ☐ Heparin 100 units per ml Directions: _____	☐ Amicar Tablet / Syrup Quantity: _____ Refill: _____ ☐ Tranexemic Acid ☐ Other: _____ ☐ Directions: _____		☐ EMLA® cream ☐ LMX-4® cream Directions: _____	

By signing this form and using this pharmacy's services, you are authorizing this pharmacy to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.

STAMP SIGNATURE NOT ALLOWED

Prescriber Signature: _____ Date: _____



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