Date:_____

Hemophilia & Bleeding Disorders Enrollment Form

PATIENT INFORMATION:

Patient Name: _____
Address: _____
City, State, Zip: _____
Cell Phone: _____
Home Phone: _____ Language: _____
Date of Birth: _____ Gender: ☐ Male ☐ Female
Guardian/Caregiver & Number: _____
Email: _____

PRESCRIBER INFORMATION:

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA: _____ NPI: _____
Office Contact: _____
Email: _____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card if available)

Insurance Name: _____
Contact Number: _____
Cardholder Name: _____ DOB: _____
ID Number: _____
Group Number: _____

Insurance Name: _____
Contact Number: _____
Cardholder: _____ DOB: _____
ID Number: _____ PCN: _____
Group Number: _____ BIN: _____

CLINICAL INFORMATION

DIAGNOSIS:

☐ D66 Hemophilia A (Factor VIII deficiency)
☐ D67 Hemophilia B (Factor IX deficiency)
☐ D68.1 Hemophilia C (Factor XI deficiency)
☐ 68.0 von Willebrand Disease
☐ D69.9 Hemorrhagic Condition, unspecified
☐ D68.4 Acquired Coagulation Factor Deficiency
☐ D68.8 Other Specified Coagulation Defects
☐ Other: _____

Severity: ☐ Mild ☐ Moderate ☐ Severe ☐ Type vWD_____
Inhibitor Hx: ☐ None ☐ Past Inhibitor ☐ Current _____ BU/ml
Patient Weight: _____ Patient Height: _____
Allergies: _____
Access: ☐ Port ☐ PICC ☐ Central Line ☐ Peripheral ☐ Other: _____
Protocol: ☐ Pre-Surgical ☐ Post-Surgical ☐ Prophylaxis ☐ Immune Tolerance ☐ On-Demand
Target Joints: _____
Followed by Treatment Center ☐ No ☐ Yes_____

PRESCRIPTION INFORMATION

Medication			Directions	Quantity	Refills
☐ Advate ☐ Adynovate ☐ Afstyla ☐ Alphanate ☐ AlphaNine ☐ Alprolix ☐ Bebulin ☐ BeneFix ☐ Corifact ☐ Coagadex ☐ Eloctate ☐ Feiba NF	☐ Helixate ☐ Hemlibra ☐ Hemofil ☐ Humate - P ☐ Idelvion ☐ Ixinity ☐ Jivi ☐ Koate –DVI ☐ Kogenate FS ☐ Kovaltry ☐ Monoclate -P ☐ Mononine	☐ NovoEight ☐ Novoseven ☐ Nuwiq ☐ Obizur ☐ Profilnine ☐ Rebinyn ☐ Recombinate ☐ RiaSTAP ☐ Rixubis ☐ Tretten ☐ Wilate ☐ Xyntha	☐ **Prophylaxis** ☐ **Immune Tolerance** Infuse _____ units (+/-10%) slow IV push every _____ ☐ And as needed for bleeding episodes ☐ **Breakthrough Bleed** Infuse _____units (+/-10%) slow IV push every _____ hours/days (circle one) for a total of _____ doses as needed for bleeding episodes. Minor: ☐ _____ units every _____hour/day PRN Major: ☐ _____ units every _____hour/day PRN ☐ **Other:** _____ _____	☐ 1 month ☐ Total doses _____ ☐ Prophy _____ ☐ PRN Doses _____ ☐ _____	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11
☐ Amicar Tablet ☐ Amicar Syrup ☐ Emla ☐ Stimate ☐ Lysteda ☐ LMX			_____ _____	☐_____ ☐_____	☐____ ☐ ____

Flushes: ☐ Sod Chloride 0.9% 5ml ☐ Sod Chloride 0.9% 10ml ☐ Heparin 10 units/ml ☐ Heparin 100 units/ml **Directions:** Flush per protocol

Ancillary Supplies: ☐ As needed for administration and disposal of medications. ☐ Home medical equipment (pump, IV pole, etc)

Nursing Coordination:
☐ **YES:** Pharmacy to coordinate home health nursing visit as necessary (for education, training and/or administer medication to patient)
☐ **NO:** Nursing not necessary: ☐ Patient and/or caregiver are proficient with infusion ☐ MD Office to train/administer ☐ Nursing already established

PRESCRIBER SIGNATURE: _____ **DATE:**_____
Verbal Readback ☐ Yes ☐ No ***Stamp signature not allowed, physician signature required ***