

HEMOPHILIA & BLEEDING DISORDERS ENROLLMENT FORM

Referral Date: _____	Ship to: <input type="checkbox"/> Home <input type="checkbox"/> Office <input type="checkbox"/> Other: _____
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PATIENT INFORMATION			
Patient Name: _____	Date of Birth: _____	Gender: _____	
Home Phone: _____	Cell Phone: _____	Email: _____	
Address: _____	City: _____	State: _____	Zip: _____
Emergency Contact: _____		Emergency Phone: _____	

INSURANCE INFORMATION	PRESCRIBER INFORMATION
Primary Insurance: _____	Prescriber Name: _____
ID #: _____ Group #: _____	DEA #: _____ NPI #: _____
Secondary Insurance: _____	Address: _____
ID #: _____ Group #: _____	City: _____ State: _____ Zip: _____
Prescription Card ID: _____ BIN #: _____	Phone: _____ Fax: _____
PCN #: _____ Group #: _____	Contact Person: _____

DIAGNOSIS	PATIENT EVALUATION
<input type="checkbox"/> D66 - Hemophilia A (Factor VIII Deficiency) <input type="checkbox"/> D67 - Hemophilia B (Factor IX Deficiency) <input type="checkbox"/> D68.1 - Hemophilia C (Factor XI Deficiency) <input type="checkbox"/> D68.2 - Hereditary Deficiency of other Clotting Factors <input type="checkbox"/> D68.0 - Von Willebrand's Disease <input type="checkbox"/> D69.9 - Hemorrhagic Condition, Unspecified <input type="checkbox"/> D68.4 - Acquired Coagulation Factor Deficiency <input type="checkbox"/> D68.8 - Other Specified Coagulation Defects <input type="checkbox"/> Other: _____	Patient Weight: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Patient Height: _____ <input type="checkbox"/> cm <input type="checkbox"/> in Allergies: _____ Inhibitor: <input type="checkbox"/> No <input type="checkbox"/> Historical <input type="checkbox"/> Current Current Medications: _____ Factor Deficiency: <input type="checkbox"/> Severe (<1%) <input type="checkbox"/> Moderate (1-5%) <input type="checkbox"/> Mild (>5%) Line Access: <input type="checkbox"/> Port <input type="checkbox"/> PICC <input type="checkbox"/> PIV <input type="checkbox"/> Butterfly <input type="checkbox"/> Other: _____ Injection Training/Home Health RN visit is necessary: <input type="checkbox"/> Yes <input type="checkbox"/> No Site of Care: <input type="checkbox"/> Home <input type="checkbox"/> MD Office <input type="checkbox"/> Other: _____

PRESCRIPTION INFORMATION	RX to include diluents, needles, syringes, ancillary supplies, home medical equipment to administer infusion.
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Factor VIII	<input type="checkbox"/> Advate® <input type="checkbox"/> Adynovate® <input type="checkbox"/> Afstyla® <input type="checkbox"/> Alphanate® SDHT <input type="checkbox"/> Altuviiio® <input type="checkbox"/> Eloctate® <input type="checkbox"/> Esperoct® <input type="checkbox"/> Helixate® FS <input type="checkbox"/> Hemofil® M <input type="checkbox"/> Humate-P® <input type="checkbox"/> Jivi® <input type="checkbox"/> Koate® <input type="checkbox"/> Kogenate® FS <input type="checkbox"/> Kovaltry® <input type="checkbox"/> NovoEight® <input type="checkbox"/> Nuwiq® <input type="checkbox"/> Recombinate® <input type="checkbox"/> Vonvendi® <input type="checkbox"/> Xyntha® <input type="checkbox"/> Wilate®
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Factor IX	<input type="checkbox"/> AlphaNine® SDVF <input type="checkbox"/> Alprolix® <input type="checkbox"/> Benefix® <input type="checkbox"/> Idelvion® <input type="checkbox"/> Ixinity® <input type="checkbox"/> Rebinyn® <input type="checkbox"/> Rixubis®
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Inhibitor Therapies	<input type="checkbox"/> Feiba® VH <input type="checkbox"/> NovoSeven® <input type="checkbox"/> Sevenfact®
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Dose and Directions	<input type="checkbox"/> Prophylaxis: Infuse _____ units (+/- _____%) slow IV-push every _____ <input type="checkbox"/> Breakthrough Bleed: For bleeding episodes: Infuse _____ units (+/- _____%) slow IV-push _____ for a total of _____ doses. For minor bleeds: Infuse _____ IU every _____ For major bleeds: Infuse _____ IU every _____ <input type="checkbox"/> Other: _____	Quantity	Refills
		# of Prophy Doses	
		# of PRN Doses	

Subcutaneous	<input type="checkbox"/> Hemlibra® Inject _____ mg (_____ mL) subcutaneously every _____ week(s).
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Other	
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Flush Protocol	<input type="checkbox"/> NaCl 0.9% 5mL <input type="checkbox"/> NaCl 0.9% 10mL <input type="checkbox"/> Heparin 10 units per mL <input type="checkbox"/> Heparin 100 units per mL	Use as needed before/after infusion to maintain IV access and patency, or as final flush.
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Other Medication	<input type="checkbox"/> Amicar® Tablet/Syrup Directions: _____ <input type="checkbox"/> Lidocaine 2.5%/Prilocaine 2.5% Cream (May dispense Lidocaine 4%) Directions: Apply to injection site(s) at least 1 hour prior to needle insertion.		
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PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

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.

<input type="checkbox"/> Dispense as Written/Brand Medically Necessary/Do Not Substitute/No Substitution/May Not Substitute Prescriber Signature _____ Date _____	<input type="checkbox"/> May Substitute/Product Selection Permitted/Substitution Permissible Prescriber Signature _____ Date _____
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CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" **NY & Iowa** providers, please submit electronic prescription.

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