



Attn: _____
 Fax Referral To: 800-546-2172
 Phone: 888-315-3395

Hemophilia Referral Form

Date: _____ Needs by Date: _____ Ship to: Patient Office

PATIENT INFORMATION

(Complete the following or send patient demographic sheet)

Patient Name: _____
 Address: _____
 City, State, Zip: _____
 Home Phone: _____
 Alternate Phone: _____
 SS #: _____
 Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
 State License #: _____ UPIN: _____
 DEA #: _____ NPI #: _____
 Group or Hospital: _____
 Address: _____
 City, State Zip: _____
 Phone: _____ Fax: _____
 Contact Person: _____ Phone: _____

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

Primary Insurance: Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____
 Secondary Insurance: Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____

Diagnosis:

Date of Diagnosis: _____

- 286.0 Hemophilia A (Factor VIII Deficiency) 286.1 Hemophilia B (Factor IX Deficiency)
 286.2 Hemophilia C (Factor XI Deficiency) Other: _____
 286.4 von Willebrand Disease Type: 1 2 3

Home Health Nursing Coordination:

- Patient Self Administers Yes No
- Specialty Pharmacy to coordinate home health nursing visit as necessary. Yes No *Agency of choice: _____
- Home health nursing visit coordination is not necessary. Reason: MD office trained patient Home health nursing already coordinated

Pertinent Medical/Bleeding History:

- PATIENT WEIGHT: _____ lbs • Allergies: _____
- Severity: Severe (<1% activity) Moderate (1-5% activity) Mild (>5% activity) • Circulating Factor: _____ %
- Inhibitor: No Historical Current: _____ B.U.
- Target Joints: Knee Elbow Ankles Shoulder Wrist Hip Other Bleeds: _____
- Vascular Access Method: peripheral port Other: _____
- Concomitant Medications: _____

PRESCRIPTION INFORMATION

Factor VIII Concentrates & VWD

- Advate
 Alphanate
 Helixate FS
 Hemofil M
 Koate-DVI
 Kogenate FS
 Monarch-M
 Monoclate-P
 Recombinate
 ReFacto
 Xyntha
 Humate P
- Therapy Regimen:
 Prophylaxis _____ / week
 Target Total Dose: _____ IU/Infusion
 # dose _____ refills _____
 Breakthrough bleed (dose):
 Minor: _____ /IU Infusion
 Major: _____ /IU Infusion
 # dose _____ refills _____
 Immune tolerance:
 Target Total Dose: _____ IU/Infusion
 # dose _____ refills _____

Anti-Inhibitor Products

- Feiba VH
 NovoSeven RT
 NovoSeven
- Therapy Regimen:
 Prophylaxis _____ / week # dose _____ refills _____
 Target Total Dose: _____ IU/Infusion
 Breakthrough bleed (dose): # dose _____ refills _____
 Minor: _____ /IU Infusion
 Major: _____ /IU Infusion
 Immune tolerance: # dose _____ refills _____
 Target Total Dose: _____ IU/Infusion

Other

- | | Qty | Refill |
|--------------------------------------|---|--------|
| <input type="checkbox"/> Stimate | <input type="checkbox"/> (<50kg): 150mcg (single spray) in one nostril | |
| | <input type="checkbox"/> (>50kg): 300mcg (single spray) in both nostril | |
| <input type="checkbox"/> DDAVP Inj | <input type="checkbox"/> 4mcg/ml Sig: _____
<input type="checkbox"/> 5mcg/ml | |
| <input type="checkbox"/> Other Meds: | Dose: _____ Sig: _____ | |

Factor IX Concentrates

- BeneFIX
 Mononine
 Alphanine SD
 Bebulin VH
 Profilnine SD
- Therapy Regimen:
 Prophylaxis _____ / week # dose _____ refills _____
 Target Total Dose: _____ IU/Infusion
 Breakthrough bleed (dose): # dose _____ refills _____
 Minor: _____ /IU Infusion
 Major: _____ /IU Infusion
 Immune tolerance: # dose _____ refills _____
 Target Total Dose: _____ IU/Infusion

Concentrates of Antithrombotic Factors

- Thrombate III
- Breakthrough bleed (dose): # dose _____ refills _____
 Minor: _____ /IU Infusion
 Major: _____ /IU Infusion
- Flushing Protocol: Sodium Chloride 0.9% _____ ml/dose Pre _____ ml/dose Post
 - Heparin 100 units/ml _____ units/dose
 - Heparin 10 units/ml _____ units/dose

Ancillary Supplies and Kits Provided as Needed for Administration.

* Pharmacy will dispense up to ± 10% of prescribed dose.

PRODUCT SUBSTITUTION PERMITTED

(Date)

DISPENSE AS WRITTEN

(Date)

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