

Last Name	First Name	Parent/Guardian	Today's Date	Date Needed
Home Phone Number () ()		Work Phone Number () ()	Prescriber	Hospital/Clinic
Home Address		City	State	Zip
Shipping Address (if different from home address) <input type="checkbox"/> Physician <input type="checkbox"/> Home <input type="checkbox"/> Other			Phone Number () ()	Fax Number () ()
Language Preference <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other			Emergency Contact Number for Hemophilia Coordinator () ()	
Social Security Number		Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth	Preference: <input type="checkbox"/> Fax <input type="checkbox"/> Phone <input type="checkbox"/> Email Email:

INSURANCE INFORMATION (fill out entirely or fax a copy of patient's insurance card, both sides)

Primary Insurance: _____

Name of Insured: _____

Policy #: _____

Group #: _____

Phone #: _____

Rx Drug Card #: _____

Secondary Insurance: _____

Name of Insured: _____

Policy #: _____

Group #: _____

Phone #: _____

Rx Drug Card #: _____

Medical History

Patient Weight _____ lbs kg On Date: _____

Allergies: _____

Last bleeding episode: _____ Baseline factor level: _____

Frequency of bleeding episodes: _____

History of use of other products: _____

Target joints or any history of joint problems: _____

Other health conditions: _____

Primary Diagnosis (ICD-9-CM Code plus description):

286.0 Hemophilia A

286.1 Hemophilia B

286.4 Von Willebrands / Vascular

Other _____

TAPE PRESCRIPTION HERE PRIOR TO FAXING REFERRAL OR COMPLETE THE FOLLOWING:

FACTOR VIIA - RECOMBINANT

NovoSeven RT Other : _____

FACTOR VIII - RECOMBINANT

Advate Helixate FS

Kogenate FS Recombinate

Xyntha Other : _____

FACTOR VIII - HUMAN MONOCLONAL

Hemofil M Other : _____

Monoclate P

FACTOR IX - RECOMBINANT

BeneFix Other : _____

FACTOR IX - HUMAN MONOCLONAL

Alphanine SD

Mononine

Other : _____

HUMAN COMPLEX (II, VII, IX, X)

Bebulin VH

Profilnine SD

FACTOR VIII - HUMAN (CONTAINS VON WILLEBRAND FACTOR)

Alphanate

Humate P (Dose in RCOF units)

Koate DVI Other : _____

ANTI-INHIBITOR COAGULANT COMPLEX

Feiba Other : _____

DESMOPRESSIN

DDAVP 4mcg/ml inj. Stimate nasal spray

Dosing Directions: _____

AMICAR

250mg/cc syrup

500mg Tab

1000mg Tab

Dosing Directions: _____

DOSING DIRECTIONS FOR FACTORS:

Episodic _____

Life-threatening _____

Prophylaxis/Breakthrough _____

Additional Order _____

Other Directions _____

Quantity: _____ Doses per month

Refill x: _____

FLUSHES

Access: Peripheral Port Other _____

Sodium Chloride 0.9% _____ ml/dose Pre _____ ml/dose Post

Heparin 100 units/ml _____ units/dose

Heparin 10 units/ml _____ units/dose

Other _____

PHYSICIAN SIGNATURE REQUIRED TO VALIDATE PRESCRIPTIONS

Physicians Signature: _____ UPIN/DEA #: _____ State License#: _____