For assistance, contact your pharmacy representative: _____ Phone:_____**(For providers only)**

Note: This form is intended for prescriber use only, if faxed, the fax must come from MD office or hospital **(may not be faxed by patient)**.

Hemophilia & Bleeding Disorders

Prescription/Pharmacy Intake Form

Pharmacy: _____

Pharmacy Fax: _____ Pharmacy Phone:_____

Date Needed: _____ **Ship To:** ☐Prescriber's Office ☐Patient's Home ☐Other: _____

PATIENT INFORMATION

Patient name: _____ DOB: _____ ☐Male ☐Female

Address:_____

City: _____ State:_____ Zip code:_____

Phone # (Daytime):_____ Phone # (Evening):_____

E-mail Address: _____ Case Manager: _____

Insurance provider **(Please include copy of front and back of card)**: _____

ID #: _____ Policy/Group #:_____ Phone #: _____ ☐Patient is eligible for Medicare

Name of Insured: _____ Employer:_____

Relationship to Patient: ☐Self ☐Other: _____ Prescription Card: ☐Yes ☐No Carrier: _____ Policy/Group #:_____

Will there be access to anaphylactic medications and oxygen at the administration site?_____

CLINICAL ASSESSMENT – Please complete ALL sections to avoid delays in filling prescription.

☐Patient is new to therapy ☐Therapy continuation Start date:_____

Primary Diagnosis Code and Condition (ICD-10):_____ Date of Diagnosis:_____

Other Diagnosis/Conditions:_____ Current Height:_____ Current Weight: _____

Allergies: _____

Clinical Features: Circulating factor level % _____ Severity ☐Mild(>5% activity) ☐Moderate (1-5% activity) ☐Severe (<1% activity)

Joints affected ☐No ☐Yes (specify) _____ Inhibitor ☐No ☐Historical ☐Yes – Current BU: _____

Indication: ☐Prophylaxis ☐On-Demand ☐Pre-surgery or procedure ☐Other: _____

IV Access: ☐Peripheral ☐Port ☐PICC

Flush Protocol: ☐5cc 0.9% NaCl before and after infusion ☐Other: _____

Maintain line with: ☐1cc 10U/cc heparin (peripheral) ☐3cc 100u/cc heparin (PICC) ☐5cc 100U/cc heparin (port)

Nursing Care: ☐Home nursing needed ☐Nursing already coordinated - - Agency: _____ Phone: _____

☐Infused in office ☐Patient self-administers

Supplies: **Pharmacy to provide all supplies and ancillary equipment necessary for home infusion**

PRESCRIPTION INFORMATION

Medication	Range/Variance +/- %	Dose	Quantity	Directions/Frequency	Refills
Factor VIII ☐Advate ☐Adynovate ☐Afstyla ☐Alphanate ☐Altuviiio ☐Eloctate ☐Helixate FS ☐Hemofil M ☐Koate ☐Kogenate FS ☐Kovaltry ☐Monoclate P ☐Novoeight ☐Recombinate ☐Xyntha					
Factor IX ☐AlphaNine SD ☐Alprolix ☐Bebulin ☐Benefix ☐Idelvion ☐Ixinity ☐Mononine ☐Profilnine ☐Rixubis					
Von Willebrand Disease ☐Humate P ☐Wilate					
Factor VII and Anti-inhibitor ☐Feiba ☐NovoSeven					
Ancillary ☐Amicar ☐Cyklokapron ☐Lysteda ☐Stimate nasal spray ☐Tranexemic Acid					
☐**Other**					
☐Epinephrine injection ☐0.15 mg ☐0.3 mg	1 kit (2 pens) – Inject 1 pen intramuscularly in lateral thigh muscle for severe allergic reaction; may repeat in 5 to 15 minutes if symptoms persist and call 911				

I authorize, by my signature below, the dispensing of appropriate needles and syringes, in a sufficient quantity, required for the administration of injectable products by patient or caregiver. Authorization for supplies runs concurrently with the number of refills or time frame specified for the drug.

PRESCRIBER INFORMATION

Prescriber's name: _____ Practice/facility:_____

Address:_____ City: _____ State: _____ Zip code: _____

Office contact: _____ Phone: _____ Fax:_____

Email:_____ Best time to call: _____ Preferred method of contact: ☐Email ☐Phone ☐Fax

State license #:_____ DEA #: _____ NPI #:_____ Medicaid UPIN #:_____

In order for a brand name product to be dispensed, the prescriber must handwrite **"Brand Necessary"** or **"Brand Medically Necessary"** or your state specific required language after their signature. I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge. Prescriber's signature required on one of the lines below.

_____ Dispense as written

_____ Substitution permitted

_____ Date

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.