Hemophilia Patient Referral Form

Patient Demographics Information

Patient Name	SSN#	DOB

Patient Address

Primary Phone	Cellular Phone	Work Phone

Emergency Contact Name, Relationship	Emergency Contact Phone Number

Additional Documentation Needed

- ❁ Copy of insurance cards
- ❁ Patient face sheet w/demographics
- ❁ Baseline labs
- ❁ History and Physical
- ❁ Inhibitor activity
- ❁ Medications list

Patient Insurance Information

Insurance Plan #1		Insurance Plan #2	
Subscriber Name	DOB	Subscriber Name	DOB
Policy Number	Group ID	Policy Number	Group ID

Patient Clinical Information

Gender ☐M ☐F	Height (inches)	Weight (lbs)	Allergies (food/drug)

Primary Diagnosis & Access Information

☐ D66	Type A: Factor VIII deficiency	☐ D68.2	Hereditary deficiency of other clotting factors
☐ D67	Type B: Factor IX deficiency	☐ D68.32	Hemorrhagic disorder due to extrinsic circulating anticoagulants
☐ D68.0	Von Willebrand disease	☐ D68.4	Acquired coagulation factor deficiency
☐ D68.1	Type C: Factor XI deficiency	☐ OTHER	_____

Date of Diagnosis:	Circulating Factor:	Target Joints: ☐ NO ☐ YES _____

Severity: ☐ Severe (<1%) ☐ Moderate (1-5%) ☐ Mild (>5%)

Inhibitor Activity: ☐ None ☐ Historical ☐ Current _____ BU/ml

Line Access Information: ☐ Peripheral Butterfly ☐ PICC ☐ Port

Medication Information, Prescription and Orders

Factor VIIa (Recombinant)	☐ NovoSeven® RT			
Factor VIII (Recombinant)	☐ Advate®	☐ Adynovate®	☐ Afstyla®	☐ Eloctate™
	☐ Helixate® FS	☐ Kogenate® FS	☐ Kovaltry®	☐ NovoEight®
	☐ Nuwiq®	☐ Recombinate®	☐ Xyntha®	
Factor VIII (Human)	☐ Hemofil® M	☐ Monoclate-P®		
Factor VIII (Human) + VWF	☐ Alphanate® SD	☐ Humate-P®	☐ Koāte® DVI	☐ Wilate®
VWF (Recombinant)	☐ VonVendi®			
Factor IX (Recombinant)	☐ Alprolix®	☐ Benefix® RT	☐ Idelvion®	
	☐ Ixinity®	☐ Rixubis®		
Factor IX (Human)	☐ AlphaNine® SD	☐ Mononine®		
Factor X (Human)	☐ Coagadex®			
Factor XIII (Human)	☐ Corifact®			
Anti-Inhibitor (Human)	☐ Feiba®			
Pro-Thrombin Complex (Human)	☐ Belubin® VH	☐ Profilnine® SD		

Therapy Regimen for Factor or Inhibitor Products	☐ Prophylaxis _____ / week ☐ Target Dose: _____ IU/kg ☐ Dose: _____ IU±___ % (Assay variation) # Doses: _____ Refills: _____	☐ Breakthrough Bleed ☐ Minor: _____ ± _____ % ☐ Moderate: _____ ± _____ % ☐ Major: _____ ± _____ % # Doses: _____ Refills: _____	☐ Immune Tolerance ☐ Target Dose: _____ IU/kg ☐ Dose: _____ IU±___ % (Assay variation) # Doses: _____ Refills: _____	☐ Other Regimen ☐ Target Dose: _____ IU/kg ☐ Dose: _____ IU±___ % (Assay variation) # Doses: _____ Refills: _____

Flushing Protocol ☐ Sodium Chloride 0.9% 5-10mL pre and post medications ☐ Heparin _____ Units/mL _____ mL as needed _____ # QS

Ancillary Supplies ☐ As needed for proper administration and disposal of medication

Skilled Nursing Visits ☐ As needed for IV access, administration, teaching and proper clinical monitoring. All nursing services per pharmacy protocol

Other Medications				
	☐ Amicar®	Directions:	Qty:	Refills:
	☐ Lysteda®	Directions:	Qty:	Refills:
	☐ Stimate®	Directions:	Qty:	Refills:
	☐	Directions:	Qty:	Refills:

Prescriber Information

Physician Name	Office Contact

Practice Address	Practice Phone & Fax Number

NPI#	License #	DEA#

Physician Signature Required - Substitution Permitted	Date	Physician Signature Required - Dispense as Written	Date