

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

<input type="checkbox"/> Copy of insurance cards	<input type="checkbox"/> Baseline labs	<input type="checkbox"/> Inhibitor activity
<input type="checkbox"/> Patient face sheet w/demographics	<input type="checkbox"/> History and Physical	<input type="checkbox"/> 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 <input type="checkbox"/> M <input type="checkbox"/> F	Height (inches)	Weight (lbs)	Allergies (food/drug)
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Primary Diagnosis & Access Information

<input type="checkbox"/> D66 Type A: Factor VIII deficiency	<input type="checkbox"/> D68.2 Hereditary deficiency of other clotting factors
<input type="checkbox"/> D67 Type B: Factor IX deficiency	<input type="checkbox"/> D68.32 Hemorrhagic disorder due to extrinsic circulating anticoagulants
<input type="checkbox"/> D68.0 Von Willebrand disease	<input type="checkbox"/> D68.4 Acquired coagulation factor deficiency
<input type="checkbox"/> D68.1 Type C: Factor XI deficiency	<input type="checkbox"/> OTHER

Date of Diagnosis:	Circulating Factor:	Target Joints: <input type="checkbox"/> NO <input type="checkbox"/> YES _____
Severity: <input type="checkbox"/> Severe (<1%) <input type="checkbox"/> Moderate (1-5%) <input type="checkbox"/> Mild (>5%)	Inhibitor Activity: <input type="checkbox"/> None <input type="checkbox"/> Historical <input type="checkbox"/> Current _____ BU/ml	

Line Access Information:
 Peripheral Butterfly PICC Port

Medication Information, Prescription and Orders

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

Therapy Regimen for Factor or Inhibitor Products	<input type="checkbox"/> Prophylaxis _____ / week <input type="checkbox"/> Target Dose: _____ IU/kg <input type="checkbox"/> Dose: _____ IU± _____ % (Assay variation) # Doses: _____ Refills: _____	<input type="checkbox"/> Breakthrough Bleed <input type="checkbox"/> Minor: _____ ± _____ % <input type="checkbox"/> Moderate: _____ ± _____ % <input type="checkbox"/> Major: _____ ± _____ % # Doses: _____ Refills: _____	<input type="checkbox"/> Immune Tolerance <input type="checkbox"/> Target Dose: _____ IU/kg <input type="checkbox"/> Dose: _____ IU± _____ % (Assay variation) # Doses: _____ Refills: _____	<input type="checkbox"/> Other Regimen <input type="checkbox"/> Target Dose: _____ IU/kg <input type="checkbox"/> Dose: _____ IU± _____ % (Assay variation) # Doses: _____ Refills: _____
	Flushing Protocol <input type="checkbox"/> Sodium Chloride 0.9% 5-10mL pre and post medications <input type="checkbox"/> 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	<input type="checkbox"/> Amicar® Directions: _____	Qty: _____	Refills: _____
	<input type="checkbox"/> Lysteda® Directions: _____	Qty: _____	Refills: _____
	<input type="checkbox"/> Stimate® Directions: _____	Qty: _____	Refills: _____
	<input type="checkbox"/> _____ 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