HERITAGE SPECIALTY PHARMACY

Hemophilia Patient Referral Form

Admissions Fax # 844-878-6917

Admissions Phone # 855-WE-R-RARE (855-937-7273)

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
- ❁ Medication 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	Height (inches)	Weight (lbs)	Allergies (food/drug)
☐M ☐F			

Primary Diagnosis & Access Information

ICD10: Primary Diagnosis - Description:

Date of diagnosis:	Circulating Factor:	Target Joint(s):

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

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

Line Access Information: ☐Peripheral Butterfly ☐PICC ☐Port ☐Subcutaneous

Medication Information / Prescription and Orders

Factor VIIa (Recombinant)	☐ NovoSeven RT ☐ SevenFact
Factor VIII (Recombinant)	☐ Advate ☐ Adynovate ☐ Altuviiio ☐ Afstyla ☐ Eloctate ☐ Esperoct ☐ Kovaltry ☐ Jivi ☐ NovoEight ☐ Nuwiq ☐ Recombinate ☐ Xyntha
Factor VIII (Human)	☐ Hemofil M ☐ Koate - DVI
Factor VIII Concentrate (Human)	☐ Corifact
Factor VIII (Human) + VWF	☐ Alphanate ☐ Humate-P ☐ Wilate
VWF (Recombinant)	☐ VonVendi
Factor IX (Recombinant)	☐ Alprolix ☐ Benefix ☐ Idelvion ☐ Ixinity ☐ Rixubis ☐ Rebinyn
Factor IX (Human)	☐ AlphaNine SD
Factor X (Human)	☐ Coagadex
Factor XIII A-Subunit (Recombinant)	☐ Tretten
Monoclonal Antibody (Recombinant)	☐ Hemlibra
Anti-Inhibitor (Human)	☐ Feiba
Pro-Thrombin Complex (Human)	☐ Profilnine SD
Anti-tissue Factor Pathway Inhibitor	☐ Alhemo ☐ Hympavzi _____ _____
Other Regimen	☐ Amicar ☐ DDAVP ☐ Tranexamic Acid ☐ Other _____

Therapy Regimen for Factor or Inhibitor Products	
	☐ Prophylaxis _____ IU/mg _____/week
	☐ Breakthrough Bleed ☐ Mild: _____ IU ☐ Moderate: _____ IU ☐ Severe: _____ IU
	☐ Immune Tolerance Dose: _____ IU
	☐ Other Regimen Dose: _____ IU

Prescriber Information

Physician Name	Office Contact

Practice Address	Practice Phone

NPI#	License #	DEA#

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