


<b>Hemophilia &amp; Bleeding Disorders Enrollment Form</b>	<b>Superior Biologics</b> <b>Fax Referral To: 914-747-1170</b> <b>Phone: 855-747-1150</b>	
Date: _____		

<b>PATIENT INFORMATION</b>	<b>PRESCRIBER INFORMATION</b>
Patient Name: _____ Address: _____ City, _____ State, Zip: _____ Home Phone: _____ Cell _____ Phone: _____ Alternate Phone: _____ Date _____ of Birth: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Prescriber Name: _____ Contact Person: _____

<b>INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card)</b>			
Primary Insurance: _____	ID#: _____	Group: _____	
Secondary Insurance: _____	ID#: _____	Group: _____	
Prescription Card: _____	ID#: _____	BIN: _____	PCN: _____ Group: _____

<b>DIAGNOSIS</b>	<b>PATIENT EVALUATION</b>
<input type="checkbox"/> D66 Hemophilia A (Factor VIII deficiency) <input type="checkbox"/> D67 Hemophilia B (Factor IX deficiency) <input type="checkbox"/> D68.1 Hemophilia C (Factor XI deficiency) <input type="checkbox"/> D68.2 Hereditary Deficiency of other clotting factors <input type="checkbox"/> 68.0 von Willebrand Disease <input type="checkbox"/> D69.9 Hemorrhagic Condition, Unspecified <input type="checkbox"/> D68.4 Acquired Coagulation Factor Deficiency <input type="checkbox"/> D68.8 Other Specified Coagulation Defects  <input type="checkbox"/> Other: _____	<b>Severity:</b> <input type="checkbox"/> Severe (<1% activity) <input type="checkbox"/> Moderate (1-5% activity) <input type="checkbox"/> Mild (>5% activity) <div style="border: 1px solid black; padding: 2px;">         • Patient Weight: _____ Kg/Lbs    Height: _____ Inches/CM       </div> • Allergies: _____ • Access: <input type="checkbox"/> Port <input type="checkbox"/> PICC <input type="checkbox"/> PIV <input type="checkbox"/> Butterfly <input type="checkbox"/> Other: _____ • Nursing Coordination: o Pharmacy to coordinate home health nursing visit as necessary: <input type="checkbox"/> Yes <input type="checkbox"/> No o Home health nursing coordination not necessary. Reason: <input type="checkbox"/> MD Office to administer to Patient <input type="checkbox"/> Home health nursing already

<b>PRESCRIPTION INFORMATION</b>
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Medication	Directions	Quantity	Refills
<input type="checkbox"/> Advate <input type="checkbox"/> Adynovate <input type="checkbox"/> Afstylia <input type="checkbox"/> Alphanate <input type="checkbox"/> Eloctate <input type="checkbox"/> Hemofil-M <input type="checkbox"/> Jivi <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	<input type="checkbox"/> Alprolix <input type="checkbox"/> BeneFIX RT <input type="checkbox"/> Idelvion <input type="checkbox"/> Ixinity <input type="checkbox"/> Mononine <input type="checkbox"/> Rixubis  <input type="checkbox"/> Humate-P <input type="checkbox"/> Vonvendi <input type="checkbox"/> Wilate  <input type="checkbox"/> Feiba NF <input type="checkbox"/> Novoseven RT	<input type="checkbox"/> <b>Prophylaxis</b> • Infuse _____ Units (+/-10%) slow iv-push every _____  <input type="checkbox"/> <b>Breakthrough Bleed</b> • Infuse _____ Units (+/-10%) slow iv-push every _____ hours/days (circle one) for a total of _____ doses As Needed for bleeding episodes. Minor: <input type="checkbox"/> _____ IU every _____ hour/day PRN Major: <input type="checkbox"/> _____ IU every _____ hour/day PRN  <input type="checkbox"/> <b>Other:</b> _____	<input type="checkbox"/> 1 month <input type="checkbox"/> 3 month <input type="checkbox"/> Specify _____  <input type="checkbox"/> 1 Year <input type="checkbox"/> Other _____
<input type="checkbox"/> Hemlibra	<b>Initial Dose:</b> <input type="checkbox"/> 3-mg/kg, _____ mg/kg  <b>Subsequent Dose:</b> <input type="checkbox"/> 1.5-mg/kg <input type="checkbox"/> 3-mg/kg <input type="checkbox"/> 6-mg/kg    _____ mg/kg	<b>Quantity of Vials:</b> <input type="checkbox"/> _____ 30mg/mL <input type="checkbox"/> _____ 60mg/0.4mL <input type="checkbox"/> _____ 105mg/0.7mL <input type="checkbox"/> _____ 150mg/mL	

<input type="checkbox"/> Amicar Tablet/Syrup    Directions: _____    Qty: _____ Refill _____ <input type="checkbox"/> NaCl 0.9% Flush <input type="checkbox"/> Heparin 10 u/ml Flush <input type="checkbox"/> Heparin 100 u/ml Flush    (Direction/Qty. Per flush protocol)
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<b>Prescriber Signature:</b> _____	<b>Date:</b> _____
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