Hemophilia & Bleeding Disorders Enrollment Form	Superior Biologics Fax Referral To: 914-747-1170 Phone: 855-747-1150	SUPERIOR BIOLOGICS

Date: _____

PATIENT INFORMATION

Patient Name: _____
Address: _____ City,
State, Zip: _____ Home Phone: _____ Cell
Phone: _____ Alternate Phone: _____ Date
of Birth: _____ Gender: ☐ M ☐ F

PRESCRIBER INFORMATION

Prescriber Name: _____
Contact Person: _____

INSURANCEINFORMATION *(Pleaseattachthe frontandback of insuranceand prescriptiondrugcard)*

Primary Insurance: _____ ID#: _____ Group: _____
Secondary Insurance: _____ ID#: _____ Group: _____
Prescription Card: _____ ID#: _____ BIN: _____ PCN: _____ Group: _____

DIAGNOSIS

☐ D66 HemophiliaA(FactorVIIIdeficiency)
☐ D67 Hemophilia B (Factor IX deficiency)
☐ D68.1HemophiliaC(FactorXIdeficiency)
☐ D68.2 Hereditary Deficiency of other clotting factors
☐ 68.0 von Willebrand Disease
☐ D69.9HemorrhagicCondition,Unspecified
☐ D68.4 Acquired Coagulation Factor Deficiency
☐ D68.8 Other Specified Coagulation Defects

☐ Other: _____

PATIENT EVALUATION

Severity:

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

- PatientWeight: _____Kg/Lbs Height: _____Inches/CM
- Allergies: _____
- Access:☐Port ☐PICC ☐PIV ☐ Butterfly ☐Other: _____
- Nursing Coordination:
  - Pharmacy to coordinate home health nursing visit as necessary: ☐Yes ☐ No
  - Home health nursing coordination not necessary. Reason:
    ☐ MD Office to administer to Patient ☐ Home health nursing already

PRESCRIPTION INFORMATION

Medication		Directions	Quantity	Refills
☐ Advate ☐ Adynovate ☐ Afstyla ☐ Alphanate ☐ Eloctate ☐ Hemofil-M ☐ Jivi ☐ KogenateFS ☐ Kovaltry ☐ NovoEight ☐ Nuwiq ☐ Recombinate ☐ Xyntha	☐ Alprolix ☐ BeneFIX RT ☐ Idelvion ☐ Ixinity ☐ Mononine ☐ Rixubis ☐ Humate-P ☐ Vonvendi ☐ Wilate ☐ Feiba NF ☐ Novoseven RT	☐ ***Prophylaxis*** • Infuse _____Units (+/-10%) slow iv-push every _____ ☐ ***Breakthrough Bleed*** • Infuse _____Units (+/-10%) slow iv-push every _____hours/days (circle one) for a total of _____doses As Needed for bleeding episodes. Minor: ☐_____IU every_____hour/day PRN Major: ☐_____IU every_____hour/day PRN ☐ ***Other:*** _____	☐ 1month ☐ 3month ☐ Specify _____	☐ 1 Year ☐ Other _____
☐ Hemlibra	**Initial Dose:** ☐ 3-mg/kg, _____ mg/kg **Subsequent Dose:** ☐ 1.5-mg/kg ☐ 3-mg/kg ☐ 6-mg/kg _____mg/kg	**Quantity of Vials:** ☐ ___30mg/mL ☐ ___60mg/0.4mL ☐ ___105mg/0.7mL ☐ ___150mg/mL		

☐ AmicarTablet/Syrup Directions: _____ Qty: _____ Refill _____
☐ NaCl 0.9% Flush ☐ Heparin 10 u/ml Flush ☐ Heparin 100 u/ml Flush (Direction/Qty. Per flush protocol)

PrescriberSignature: _____ **Date:** _____