Hemophilia & Bleeding Disorders
Referral Form

Date: ____________________________

HOM T CH A VANC TH RAPI
Fa Referral To: 55- 4-92 3
Phone: 55-494-3121

PATIENT INFORMATION

Patient Name: ___________________________________
Address: ___________________________________
City, State, Zip: ___________________________________
Home Phone: ___________________________________
Cell Phone: ___________________________________

Date of Birth: ______________ Gender: ☐ M ☐ F

PRESCRIBER INFORMATION

Prescriber Name: ___________________________________
Address: ___________________________________
City, State, Zip: ___________________________________
Phone: ___________________________________
Fax: ___________________________________
DEA#: ____________________ NPI#: __________________
Contact Person: ___________________________________

INSURANCEINFORMATION *(Pleaseattachthe frontandback of insuranceand prescriptiondrugcard)*

Primary Insurance:____________________________________ID#:__________________________Group:____________
Secondary Insurance:__________________________________ID#:__________________________Group:____________
PrescriptionCard: _____________ID#:_______________BIN:____________PCN:_________Group: ____________

DIAGNOSIS

- ☐ D66 HemophiliaA(FactorVIIIdeficiency)
- ☐ D67 Hemophilia B (Factor IX deficiency)
- ☐ D68.1 HemophiliaC(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

PRESCRIPTION INFORMATION

Medication		Directions	Quantity	Refills
☐ Advate ☐ Adynovate ☐ Afstyla ☐ Alphanate ☐ Eloctate ☐ Hemofil-M ☐ Jivi ☐ Koate ☐ Kovaltry ☐ NovoEight ☐ Nuwiq ☐ Recombinate ☐ Xyntha	☐ Alprolix ☐ Alphanine SD ☐ 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:*** ________________________________	☐ 1 month ☐ 3month ☐ Specify ________	☐ 1 Year ☐ Other ________
☐ Hemlibra	**Initial Dose:** ☐ 3-mg/kg OR ☐ _____ mg/kg once weekly for 4 weeks **Subsequent Dose:** ☐ 1.5-mg/kg q week ☐ 3-mg/kg q 2 weeks ☐ 6-mg/kg q 4 weeks _____mg/kg q ___ weeks	**Quantity of Vials:** ☐ ___30mg/mL ☐ ___60mg/0.4mL ☐ ___105mg/0.7mL ☐ ___150mg/mL		

☐ AmicarTablet/Syrup Directions:____Qty:_____Refill _____

IV Access Flush Order: NaCl 0.9% 5-10ml IV before and after infusion, Heparin 10 Units/ml 5ml after infusion for PICC/Midline, Heparin 10 Units/ml 3ml after infusion for PIV, Heparin 100 Units/ml 5ml IV after infusion for PORT, All infusion supplies necessary to administer the medication

PrescriberSignature:___________________________________ Date: ______________________

The information contained in this facsimile may be confidential and is intended solely for the use of the named recipient(s). Access, copying or re-use of the facsimile or any information contained therein by any other person is not authorized. If you are not the intend recipient, please notify us immediately by calling or faxing back to the originator.