# Hemophilia & Bleeding Disorders Referral Form

Date: _____

**SUPERIOR BIOLOGICS**
**Fax Referral To: 914-747-1170**
**Phone: 855-747-1150**

SUPERIOR BIOLOGICS

## 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: _____

## INSURANCE INFORMATION *(Please attach the front and back of insurance and prescription drug card)*

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

## DIAGNOSIS

☐ D66 HemophiliaA(FactorVIII deficiency)
☐ D67 Hemophilia B (Factor IX deficiency)
☐ D68.1 HemophiliaC(FactorXI deficiency)
☐ D68.2 Hereditary Deficiency of other clotting factors
☐ D68.01 VWD Type 1
☐ D68.02 VWD Type 2___
☐ D68.03 VWD Type 3
☐ D69.9 Hemorrhagic Condition,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<br>☐ Adynovate<br>☐ Afstyla<br>☐ Alphanate<br>☐ Eloctate<br>☐ Hemofil-M<br>☐ Jivi<br>☐ Koate<br>☐ Kovaltry<br>☐ NovoEight<br>☐ Nuwiq<br>☐ Recombinate<br>☐ Xyntha | ☐ Alprolix<br>☐ Alphanine SD<br>☐ BeneFIX RT<br>☐ Idelvion<br>☐ Ixinity<br>☐ Mononine<br>☐ Rixubis<br>☐ Humate-P<br>☐ Vonvendi<br>☐ Wilate<br>☐ Feiba NF<br>☐ Novoseven RT | ☐ ***Prophylaxis***<br>• Infuse_____Units (+/-10%) slow iv-push every _____<br>☐ ***Breakthrough Bleed***<br>• Infuse_____Units (+/-10%) slow iv-push every _____hours/days (circle one) for a total of_____doses As Needed for bleeding episodes.<br>Minor: ☐_____IU every_____hour/day PRN<br>Major: ☐_____IU every_____hour/day PRN<br>☐ ***Other:*** _____ | ☐ 1month<br>☐ 3month<br>☐ Specify<br>_____ | ☐ 1 Year<br>☐ Other<br>_____ |
| ☐ Hemlibra | | **Initial Dose:** ☐ 3-mg/kg OR ☐ _____ mg/kg once weekly for 4 weeks<br>**Subsequent Dose:**<br>☐ 1.5-mg/kg q week ☐ 3-mg/kg q 2 weeks<br>☐ 6-mg/kg q 4 weeks _____mg/kg q ___ weeks | **Quantity of Vials:**<br>☐ ___30mg/mL<br>☐ ___60mg/0.4mL<br>☐ ___105mg/0.7mL<br>☐ ___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:** _____