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: _____

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)
- D68.1HemophiliaC(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 coordinatehomehealthnursingvisit 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: ☐ _____ units every _____ hour/day PRN Major: ☐ _____ units every _____ hour/day PRN ☐ ***Other:*** _____	☐ 1month ☐ 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:** _____