

**PATIENT INFORMATION**  Deliver Here

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Gender:  Male  Female

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ SSN: \_\_\_\_\_

Caregiver Name: \_\_\_\_\_

Alternate Phone: \_\_\_\_\_

**Please fax a copy of front and back of the insurance card(s).**

**PRESCRIBER INFORMATION**  Deliver Here

Prescriber Name: \_\_\_\_\_

State License #: \_\_\_\_\_ DEA #: \_\_\_\_\_

NPI #: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

**Clinical Information (Please fax pertinent lab information)**

Diagnosis:  D66 (Type A – Factor VIII Deficiency)  D67 (Type B – Factor IX Deficiency)

D68.1 (Type C – Factor XI Deficiency)  D68.2 (Hereditary deficiency of other clotting factors)

D68.32 (Hemorrhagic disorder due to extrinsic circulating anticoagulants)  D68.4 (Acquired coagulation factor deficiency)

D68.0 (Von Willebrand Disease)  Other: \_\_\_\_\_

Date of diagnosis: \_\_\_\_\_ Wt: \_\_\_\_\_  Kg  lbs Ht: \_\_\_\_\_  cm  in

Circulating factor \_\_\_\_\_% Target joints:  No  Yes \_\_\_\_\_ Access:  Peripheral  PICC  Implanted Port  Other: \_\_\_\_\_

Protocol:  Pre- Surgical  Prophylaxis  Immune Tolerance  On-demand Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ End Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Allergies:  NKDA  Other: \_\_\_\_\_

Comorbidities: \_\_\_\_\_

Concomitant medication: \_\_\_\_\_

**Prescription**

Factor I (Recombinant)	<input type="checkbox"/> RiaSTAP		
Factor VIIa (Recombinant)	<input type="checkbox"/> NovoSeven RT		
Factor VIII (Recombinant)	<input type="checkbox"/> Advate <input type="checkbox"/> Adynovate <input type="checkbox"/> Afstyla <input type="checkbox"/> Elocate <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		
Factor VIII (Human)	<input type="checkbox"/> Hemofil M		
Factor VIII (Human) + VWF	<input type="checkbox"/> Alphanate <input type="checkbox"/> Humate-P <input type="checkbox"/> Koate DVI <input type="checkbox"/> Wilate		
Factor IX (Recombinant)	<input type="checkbox"/> Alprolix <input type="checkbox"/> Benefix RT <input type="checkbox"/> Idelvion <input type="checkbox"/> Ixinity <input type="checkbox"/> Rixubis		
Factor IX (Human)	<input type="checkbox"/> AlphaNine SD <input type="checkbox"/> Mononine		
Factor X Activator (Human/Recombinant)	<input type="checkbox"/> Hemlibra		
Factor X (Human)	<input type="checkbox"/> Coagadex		
Factor XIII (Human)	<input type="checkbox"/> Corifact		
Factor XIII (Recombinant)	<input type="checkbox"/> Tretten		
Von Willebrand Factor (Recombinant)	<input type="checkbox"/> Vonvendi		
Anti-Inhibitor (Human)	<input type="checkbox"/> Feiba		
Pro-Thrombin Complex (Human)	<input type="checkbox"/> Bebulin VH <input type="checkbox"/> Profilnine SD		
Other: _____	Other: _____		
<b>Therapy Regimen</b>	<b>Prophylaxis</b> _____/week	<b>Breakthrough bleed</b>	<b>Immune Tolerance</b>
	Target Dose: _____ IU/kg Dose: _____ IU ± _____ % (Assay variation) # Doses: _____ Refills: _____	Minor: _____ IU ± _____ % Moderate: _____ IU ± _____ % Major: _____ IU ± _____ % # Doses: _____ Refills: _____	Target Dose: _____ IU/kg Dose: _____ IU ± _____ % (Assay variation) # Doses: _____ Refills: _____
Flushing Protocol	Normal Saline _____ mL Pre-medication	Heparin _____ Units/mL Pre-medication	
	_____ mL Post medication	_____ Units/mL Post medication	

Product substitution permitted  Dispense as written

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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