CureStat Rx
Home Infusion and Specialty Pharmacy

BLEEDING DISORDERS REFERRAL FORM

Phone: (888)963-6544 Fax: (858)281-0045

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)	☐ RiaSTAP		
Factor VIIa (Recombinant)	☐ NovoSeven RT		
Factor VIII (Recombinant)	☐ Advate ☐ Adynovate ☐ Afstyla ☐ Eloctate ☐ Jivi ☐ Kogenate FS ☐ Kovaltry ☐ NovoEight ☐ Nuwiq ☐ Recombinate ☐ Xyntha		
Factor VIII (Human)	☐ Hemofil M		
Factor VIII (Human) + VWF	☐ Alphanate ☐ Humate-P ☐ Koāte DVI ☐ Wilate		
Factor IX (Recombinant)	☐ Alprolix ☐ Benefix RT ☐ Idelvion ☐ Ixinity ☐ Rixubis		
Factor IX (Human)	☐ AlphaNine SD ☐ Mononine		
Factor X Activator (Human/Recombinant)	☐ Hemlibra		
Factor X (Human)	☐ Coagadex		
Factor XIII (Human)	☐ Corifact		
Factor XIII (Recombinant)	☐ Tretten		
Von Willebrand Factor (Recombinant)	☐ Vonvendi		
Anti-Inhibitor (Human)	☐ Feiba		
Pro-Thrombin Complex (Human)	☐ Bebulin VH ☐ Profilnine SD		
Other: _____	Other: _____		
Therapy Regimen	**Prophylaxis** _____/week Target Dose: _____ IU/kg Dose: _____ IU ± ____% (Assay variation) # Doses: _____ Refills: _____	**Breakthrough bleed** Minor: _____IU ± _____% Moderate: _____IU ± _____% Major: _____IU ± _____% # Doses: _____ Refills: _____	**Immune Tolerance** Target Dose: _____ IU/kg Dose: _____ IU ± ____% (Assay variation) # Doses: _____ Refills: _____
Flushing Protocol	Normal Saline _____mL Pre-medication _____mL Post medication	Heparin _____Units/mL Pre-medication _____Units/mL Post medication	

☐ Product substitution permitted ☐ Dispense as written

Prescriber's Signature: _____ Date: _____