

FAX FORM TO: 1.877.597.3070

PHONE: 1.800.473.3516

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Complete the following or include demographic sheet.

1. PATIENT INFORMATION		2. PRESCRIBER INFORMATION	
Name: _____		Name: _____	
Address: _____		DEA #: _____	NPI #: _____ State Lic. #: _____
City, State, ZIP: _____		Group or Hospital: _____	
Primary Phone: - -	DOB: / /	Address: _____	
Alternate Phone: - -	Gender: _____	City, State, Zip: _____	
Email: _____		Phone: - -	Fax: - -
Primary Language: _____	Last Four of SSN: _____	Contact Person: _____ Phone: - -	

3. INSURANCE INFORMATION		<i>Fax copy of prescription and insurance cards with this form, if available (front and back)</i>	
Primary Insurance Company Name: _____		Secondary Insurance Company Name: _____	
Primary Cardholder Name: _____		Secondary Cardholder Name: _____	
Relationship: <input type="radio"/> Self <input type="radio"/> Spouse/Partner <input type="radio"/> Child/Dependent		Relationship: <input type="radio"/> Self <input type="radio"/> Spouse/Partner <input type="radio"/> Child/Dependent	
Phone: - -	Member ID: _____	Group #: _____	Phone: - -
		Member ID: _____	Group #: _____

4. DIAGNOSIS AND CLINICAL INFORMATION	
Needs by Date: / /	Ship to: <input type="radio"/> Patient <input type="radio"/> Office <input type="radio"/> Other:
<input type="radio"/> D66 Hereditary factor VIII deficiency <input type="radio"/> D67 Hereditary factor IX deficiency <input type="radio"/> D68.1 Hereditary factor XI deficiency <input type="radio"/> D68.2 Hereditary deficiency of other clotting factors <input type="radio"/> Factor VII disorder <input type="radio"/> Factor XIII disorder <input type="radio"/> D68.Ø Von Willebrand disease <input type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="radio"/> Type 3 <input type="radio"/> D68.3 Hemorrhagic disorder <input type="radio"/> D68.9 Other specified coagulation defects <input type="radio"/> Other (Specify): _____	Severity: <input type="radio"/> Severe (<1% activity) <input type="radio"/> Moderate (<1-5% activity) <input type="radio"/> Mild (>5% activity)
	Circulating Factor Level: ____% Inhibitor? <input type="radio"/> No <input type="radio"/> Historical: ____ Current BU
	Target Joints: <input type="radio"/> No <input type="radio"/> Yes (Specify): _____
	Administration Nursing needed? <input type="radio"/> Yes <input type="radio"/> No Patient trained to self-administer? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> MD office to administer to patient <input type="radio"/> Home health agency coordinated administration
	Allergies: _____
Height (in/cm): _____ Weight (lb/kg): _____	Other Medications: _____
Is patient interested in patient support programs? <input type="radio"/> Yes <input type="radio"/> No	

5. PRESCRIPTION INFORMATION				
Medication	Dose/Strength	Directions	Quantity	Refills
<input type="radio"/> Advate <input type="radio"/> Epi-Pen Jr. <input type="radio"/> Novoseven RT <input type="radio"/> Adynovate® <input type="radio"/> Feiba NF <input type="radio"/> Nuwiiq® <input type="radio"/> Alphanate <input type="radio"/> Heparin <input type="radio"/> Obizur <input type="radio"/> Alphanine <input type="radio"/> Helixate <input type="radio"/> Profilnine <input type="radio"/> Alprolix® <input type="radio"/> Hemofil-M <input type="radio"/> Recombinate <input type="radio"/> Amicar tablet <input type="radio"/> Humate-P <input type="radio"/> RiaSTAP® <input type="radio"/> Amicar syrup <input type="radio"/> IXINITY® <input type="radio"/> Rixubis <input type="radio"/> Bebulin <input type="radio"/> Koate-DVI <input type="radio"/> Stimate <input type="radio"/> BeneFIX <input type="radio"/> Kogenate FS <input type="radio"/> Thrombate III <input type="radio"/> Coagadex <input type="radio"/> Kovaltry® <input type="radio"/> Xyntha <input type="radio"/> Corifact <input type="radio"/> Monoclate-P <input type="radio"/> Wilate <input type="radio"/> Eloctate® <input type="radio"/> Mononine <input type="radio"/> Other: <input type="radio"/> Epi-Pen <input type="radio"/> Novoeight®	_____ IU/kg _____ mg/kg _____ mg _____ mcg _____ mL	<input type="radio"/> Prophylaxis: _____ <input type="radio"/> Immune tolerance: _____ <input type="radio"/> Breakthrough bleed <input type="radio"/> Infuse _____ units (+/- 10%) slow IV push every _____ hours/days (circle one) for a total of _____ doses as needed for bleeding episodes. <i>Contact your physician's office if bleeding does not resolve.</i> Minor: <input type="radio"/> _____ IU q _____ hr PRN <input type="radio"/> Other: _____ Major: <input type="radio"/> _____ IU q _____ hr PRN <input type="radio"/> Other: _____	<input type="radio"/> 3 months <input type="radio"/> 1 month <input type="radio"/> Other:	<input type="radio"/> 3 months <input type="radio"/> 1 month <input type="radio"/> Other:

Ancillary supplies and kits will be provided as needed for administration.

6. PRESCRIBER SIGNATURE	
X _____ / /	X _____ / /
DISPENSE AS WRITTEN	PRODUCT SUBSTITUTION PERMITTED
DATE	DATE

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address or telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.