Hemophilia & Bleeding Disorders

□ Burbank, CA P: (818) 848-8112 F: (818) 848-8142

□ Las Vegas, NV P: (702) 478-5133 F: (702) 478-5401

QUALITY HOME INFUSION
PASSION FOR PUTTING PATIENTS FIRST

PATIENT INFORMATION (Please complete the following or fax the patient demographic sheet)

Patient Name _____ DOB _____ Last Four of SS# _____ Sex: ☐ Male ☐ Female

Address _____ City, State, ZIP _____

Main Phone _____ Alternate Phone _____ Language Preference: ☐ English ☐ Spanish ☐ Other _____

PRESCRIBER INFORMATION

Prescriber's Name _____ Address _____

NPI _____ DEA _____ Lic _____ City, State, ZIP _____

Contact Person _____ Group/Hospital _____ Phone _____ Fax _____

INSURANCE INFORMATION (Please fax a copy of patient's insurance card- both sides)

Prior Authorization Reference number _____

CLINICAL INFORMATION

Diagnosis — *Please include diagnosis name with ICD-10 code*

☐ D66 Hereditary factor VIII deficiency ☐ D67 Hereditary factor IX deficiency

☐ D68.0 Von Willebrand Disease----- ☐ Type 1 ☐ Type 2 ☐ Type 3

☐ Other: ICD-10 Code _____ Description _____

Date of Diagnosis _____

Next Infusion Date _____ Target Joints: ☐ No ☐ Yes _____

Infusion by*: ☐ Parent ☐ Patient ☐ Other _____

Access: ☐ Peripheral ☐ PICC ☐ PORT ☐ Other _____

Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight: _____ kg / lb (circle) Height: _____ cm / in (circle)

Allergies: ☐ NKDA ☐ Other _____

Historical response: ☐ High ☐ Low Date: _____

Factor Deficiency: ☐ Severe (<1%) ☐ Moderate (1-5%) ☐ Mild (>5%)

Circulating Factor: ____ % Inhibitor: ☐ Low ☐ Historical ☐ Current

Comorbidities: _____

Concomitant medications: _____

*Skilled nursing visits provided as needed

PRESCRIPTION INFORMATION (Ancillary supplies provided as needed for administration)

Medication	Dose & Directions (Dose to be +/-10% unless specified)	Quantity	Refills
Factor VIII (Recombinant) ☐ Advate® ☐ Eloctate® ☐ Kogenate FS® ☐ Nuwiq® ☐ Adynovate® ☐ Esperoct® ☐ Kovaltry® ☐ Recombinate® ☐ Afstyla® ☐ Jivi® ☐ Novoeight® ☐ Xyntha®	Assay Variation: +/-____%		
Factor VIII (Human) ☐ Hemofil M® ☐ Koate®	☐ Prophylaxis: _____	____ Doses/month	____
Factor VIII and VWF **Dose will be dispensed in vWF:RCo units unless specified otherwise ☐ Alphanate® ☐ Humate P®** ☐ Vonvendi®** ☐ Wilate®**	☐ Immune Tolerance: _____	____ Doses/month	____
Factor IX ☐ AlphaNine® SD ☐ Benefix® ☐ Ixinity® ☐ Rebinyn® ☐ Alprolix® ☐ Idelvion® ☐ Mononine® ☐ Rixubis®	☐ Breakthrough Bleeding: ☐ Minor: _____ ☐ Moderate: _____ ☐ Major: _____	____ Doses/month ____ Doses/month ____ Doses/month	____ ____ ____
Factor XIII ☐ Corifact® ☐ Tretten®	☐ Other: _____	____ Doses/month	____
Inhibitor Therapies, Factor VIIa, and other ☐ Feiba® ☐ NovoSeven® ☐ Other:_____			
Hemlibra® ☐ 30mg/mL ☐ 60mg/0.4mL ☐ 105mg/0.7mL ☐ 150mg/mL	☐ Initial dose: 3mg/kg subQ once weekly for 4 weeks ☐ Maintenance dose: 1.5mg/kg subQ once weekly ☐ Maintenance dose: 3mg/kg subQ every 2 weeks ☐ Maintenance dose: 6mg/kg subQ every 4 weeks ☐ Other: _____		
☐ EMLA® Cream, 30gm ☐ Other: _____			
☐ EPIPEN® 0.3mg ☐ EPIPEN Jr® 0.15mg	☐ Inject as needed for anaphylaxis		
Stimate® ☐ 150mcg/actuation nasal spray	☐ Wt<50kg, single spray in **one** nostril (1 spray total) ☐ Wt>50kg, single spray in **each** nostril (2 sprays total)		
Amicar® ☐ 500mg tablets ☐ 25% Oral Solution			
Lysteda® ☐ 650mg tablets			
Flushing ☐ 0.9% Normal Saline Flush, 5-10mL pre and post IV medication administration ☐ Heparin 10units/mL Flush, 3-5mLs as needed ☐ Heparin 100units/mL Flush, 1-3mLs as needed		☐ Quantity Sufficient ☐ _____	☐ PRN ☐ ____

Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Deliver to: ☐ Patient ☐ Office ☐ Other _____ Needs by Date: _____

Prescriber's Signature _____ Date _____ ☐ Substitution permitted unless this box is checked