



# Hemophilia Referral Form

Please Fax copy(s) of patient's insurance card(s) with referral.

201 Great Circle Road | Nashville, TN 37228 | Phone: 800.800.6606 | Fax: 800.330.0756

Upon Receipt of this form, pharmacy will fill covered prescriptions and send to patients' address as directed.

<b>Patient Name:</b>		Phone #:	
Address:			
DOB:	Sex:	Allergies:	
SSN#:	Patient Representative:		Marital Status:

<b>Primary Ins. Co:</b>		Ph.#:	
Name of Insured:		Relationship:	
Insured SS#:	DOB:	Employer:	
Group #:	Policy #:	Member #:	

<b>Pharmacy Benefits Manager:</b>		Ph.#:	
<b>Secondary Ins. Co:</b>		Ph.#:	
Name of Insured:		Relationship:	
Insured SS#:	DOB:	Employer:	
Group #:	Policy #:	Member #:	

<b>Pharmacy Benefits Manager:</b>		Ph.#:	
Hemophilia Type: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> vWD <input type="checkbox"/> Other		Height:	Weight:
Severity: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe			
IV Access: <input type="checkbox"/> PIV/Buttterfly <input type="checkbox"/> PICC <input type="checkbox"/> Port a Cath <input type="checkbox"/> Central Line		Inhibitors: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Target Joint(s): <input type="checkbox"/> No <input type="checkbox"/> Yes Location:			
<input type="checkbox"/> Skilled nursing visits to be provided for infusions <input type="checkbox"/> Skilled nursing visits to be provided for teaching			
Additional Requirements:			

<b>Clotting Factor Orders</b>			
Brand Name:	Dose:	Qty:	Frequency:
Brand Name:	Dose:	Qty:	Frequency:
<b>Dosage: Mild units/kg</b> _____		<b>Severe units/kg</b> _____	
Prophylaxis # Doses _____ /WK Dispense for _____ MO(S)			
Episodic Dispense _____ Doses for Mild / _____ Doses for Severe			

<b>Ancillary Meds/Supplies</b>	
<input type="checkbox"/> Amicar _____ MG Directions:	<input type="checkbox"/> Heparin _____ u/ml _____ cc flush
<input type="checkbox"/> Stimate 1.5mg/ml Spray in <input type="checkbox"/> Each <input type="checkbox"/> Both nostril(s) as directed	<input type="checkbox"/> Saline Flush _____ cc
<input type="checkbox"/> Emla Apply topically as needed to IV site one to one-half hour prior to insertion prn. _____	
<input type="checkbox"/> LMX Apply topically as needed to IV site one to one-half hour prior to insertion prn. _____	
<input type="checkbox"/> CryoCuff to be applied to affected site/joint prn _____. Site _____	
<input type="checkbox"/> Other:	

<b>Prescriber:</b>		Office Contact:	
Address:			
Phone #:		Fax #:	
License #:	UPIN #:	NPI #:	DEA #:

# Refills \_\_\_\_\_ Refill x \_\_\_\_\_ YR/MO

Dispense As Written

<div style="border: 1px solid black; width: 100px; height: 40px; margin: 0 auto;"></div>	Signature _____ Date _____
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**Tape Prescription Form Here**