Hemophilia Referral Form **Separate RX Needed**

HPC SPECIALTY PHARMACY

HEMO_ 0109-1020

PATIENT INFORMATION

Patient Name: _____

Date of Birth: ____ /____ / ____ ☐ Male ☐ Female

SSN: ____ -____ - ____

Physical Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) - ____ - _____ Emerg. Contact: _____

Email: _____ Emerg. Phone: (____) -____ -_____

Preferred method of contact: ☐ Phone ☐ Email

Height: _____ in Weight: _____ lb Date: ____ /____ / ____

Allergies: Medications:

PRESCRIPTION BENEFITS INFORMATION *(Please attach front and back of insurance card)*

Plan name: _____ ID#: _____ Group #: _____ RxBIN: _____ RxPCN: _____

PRESCRIBER INFORMATION

Prescriber Name: _____

Address: _____

City: _____ State: Oh Zip: _____

Contact: _____

Clinic/Hospital Affiliation: _____

Phone: (____) - ____ - _____

Fax: (____) - ____ - _____

License #: _____

NPI #: _____

Medicaid Provider #: _____

CLINICAL INFORMATION

Primary Diagnosis: _____

Diagnosis Code: _____

Secondary Diagnosis: _____

Diagnosis Code: _____

Bleeding Disorder Type:

☐ A B ☐ vWD ☐ Other:_____

Inhibitors:

☐ Yes ☐ No

Severity:

☐ Mild ☐ Moderate ☐ Severe ☐ Type vWD:_____

Is patient followed at a Hemophilia Treatment Center?

☐ Yes ☐ No *If Yes, Where?*_____

IV Access:

☐ Peripheral ☐ Port ☐ Central Line ☐ PICC Line

Medical Equipment:

☐ Ambulatory IV Infusion Pump ☐ Infusion Pump Pole

☐ Subcutaneous Infusion Pump ☐ Other: N/A

MEDICATION

☐ Advate®	☐ Hemofil®	☐ NovoSeven®RT
☐ Adynovate®	☐ Humate-P®	☐ Nuwiq®
☐ Afstyla®	☐ Idelvion®	☐ Obizur®
☐ Alphanate®	☐ IXINITY®	☐ Rebinyn®
☐ AlphaNine®SD	☐ Jivi®	☐ Recombinate®
☐ Alprolix®	☐ Koate®DVI	☒ Rixubis®
☐ BeneFIX®	☐ Kogenate®FS	☐ Stimate®
☐ Corifact®	☐ Kovaltry®	☐ Tretten®
☐ Eloctate®	☐ Monoclate-P®	☐ Vonvendi®
☐ Feiba®	☐ Mononine®	☐ Wilate®
☐ Hemlibra®	☐ Novoeight®	☐ Xyntha®

☐ Other: _____

Infuse _____ units IV _____ for prophy

Dispense: _____ *(include dosing schedule)*

Infuse _____ units IV _____ as needed for PRN

Dispense: _____ *(include dosing schedule)*

REFILL: _____

Infusion Training

Infusion training provided by ☐ Prescriber's Office ☐ Specialty Pharmacy ☐ Other: _____

Nursing Requirements

Nursing not Required ☐Initial one time only training ☐ Extended nursing required List Frequency and Duration : _____

PRESCRIBER SIGNATURE FOR INFUSION TRAINING AND/OR NURSING REQUIREMENT

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process. I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

_____ Signature

_____ Date

Date Shipment Needed By: ____ /____ / ____

SPECIAL INSTRUCTIONS

****Please note this is not an OFFICIAL PRESCRIPTION. Please Escribe or fax over an original prescription*******

PLEASE NOTE THIS IS NOT AN RX. YOUR SIGNATURE AUTHORIZES NURSING AND SUPPLIES ONLY. PLEASE FAX OR ESCRIBE A SEPARATE RX

HPC SPECIALTY INFUSION

PHONE: 1-800-757-9192

www.HPCSpecialtyPharmacy.com

PLEASE INCLUDE ALL MEDICAL RECORDS & LAB VALUES

PLEASE FAX TO 1-855-813-0583