

Hemophilia Enrollment Form

Date: _____ Needs by Date: _____

Ship to: Patient Office Other: _____

PATIENT INFORMATION

(Complete the following or send patient demographic sheet)

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
Last Four of SS #: _____ Primary Language: _____
Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ UPIN: _____
DEA #: _____ NPI #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

INSURANCE INFORMATION (Please copy and attach the front and back of insurance and prescription drug card)

Prescription Card: Name of Insurer: _____ ID#: _____ BIN: _____ PCN: _____ Group: _____
Primary Insurance: Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____
Secondary: Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____

STATEMENT OF MEDICAL NECESSITY

Diagnosis:
 286.0 Hemophilia A (Factor VIII Deficiency) 286.1 Hemophilia B (Factor IX Deficiency)
 286.2 Hemophilia C (Factor XI Deficiency) 286.3 Other Clotting Disorder
 286.4 von Willebrand Disease 286.7 Acquired Coagulation
Type: 1 2 3 286.9 Other Coagulation
 286.5 Hemorrhagic Disorders _____
• Date of Diagnosis: _____

Pertinent Medical/Bleeding History:
• Severity: Severe (<1% activity) Moderate (1-5% activity)
 Mild (>5% activity) • Circulating Factor: _____ %
• Inhibitor: No Historical Current: _____ B.U.
• Target Joints: No Yes • Explain: _____
• Protocols: 1° Prophylaxis 2° Prophylaxis Preventive
 Immune tolerance: _____ Other: _____
• Start Date: _____ • End Date: _____
• Vascular Access Method: peripheral central Other: _____
• Flushing Protocol: Please state flushing protocol: _____
• Patient Weight: _____ kg/lbs • Allergies: _____
• Concomitant Medications: _____

Home Health Nursing Coordination:
• Specialty Pharmacy to coordinate home health nursing visit as necessary.
 Yes No *Agency of _____
• Home health nursing visit coordination is not necessary.
Date of treatment start: _____
Reason: MD office trained patient Home health nursing already

PRESCRIPTION INFORMATION

MEDICATION	DOSE	THERAPY REGIMEN	QTY	REFILL	MEDICATION	DOSE	THERAPY REGIMEN	QTY	REFILL
Factor VIII Concentrates & VWD					Anti-Inhibitor Products				
<input type="checkbox"/> Advate	Target	Therapy Regimen:			<input type="checkbox"/> Feiba VH	Target	Therapy Regimen: <input type="checkbox"/> Prophylaxis _____ / week <input type="checkbox"/> Immune tolerance: _____ <input type="checkbox"/> Breakthrough bleed: <input type="checkbox"/> Minor: _____ <input type="checkbox"/> Major: _____		
<input type="checkbox"/> Alphanate					Dose:	<input type="checkbox"/> NovoSeven RT			
<input type="checkbox"/> Helixate FS	IU/kg	<input type="checkbox"/> Prophylaxis _____ / week <input type="checkbox"/> Immune tolerance: _____ <input type="checkbox"/> Breakthrough bleed: <input type="checkbox"/> Minor: _____ <input type="checkbox"/> Major: _____			<input type="checkbox"/> Amicar tablet	Target	Therapy Regimen: <input type="checkbox"/> Breakthrough bleed: <input type="checkbox"/> Minor: _____ <input type="checkbox"/> Major: _____		
<input type="checkbox"/> Hemofil M					Dose:	<input type="checkbox"/> Amicar syrup			
<input type="checkbox"/> Koate-DVI	IU/kg	<input type="checkbox"/> Prophylaxis _____ / week <input type="checkbox"/> Immune tolerance: _____ <input type="checkbox"/> Breakthrough bleed: <input type="checkbox"/> Minor: _____ <input type="checkbox"/> Major: _____			<input type="checkbox"/> Stimate	<input type="checkbox"/> 150mcg <input type="checkbox"/> 300mcg	<input type="checkbox"/> Single spray in one nostril < 50kg <input type="checkbox"/> Single spray in both nostrils > 50kg (total of 2 sprays)		
<input type="checkbox"/> Kogenate FS					Dose:	<input type="checkbox"/> Stimate			
<input type="checkbox"/> Monarch-M	IU/kg	<input type="checkbox"/> Prophylaxis _____ / week <input type="checkbox"/> Immune tolerance: _____ <input type="checkbox"/> Breakthrough bleed: <input type="checkbox"/> Minor: _____ <input type="checkbox"/> Major: _____			Miscellaneous				
<input type="checkbox"/> Monoclate-P					Dose:	<input type="checkbox"/> Epipen®	Use as directed.	2-Pak kit	PRN
<input type="checkbox"/> Recombinate	IU/kg	<input type="checkbox"/> Prophylaxis _____ / week <input type="checkbox"/> Immune tolerance: _____ <input type="checkbox"/> Breakthrough bleed: <input type="checkbox"/> Minor: _____ <input type="checkbox"/> Major: _____			Concentrates of Antithrombotic Factors				
<input type="checkbox"/> ReFacto					Dose:	<input type="checkbox"/> Thrombate III	Target	Therapy Regimen: <input type="checkbox"/> Breakthrough bleed: <input type="checkbox"/> Minor: _____ <input type="checkbox"/> Major: _____	
<input type="checkbox"/> Xyntha	IU/kg	<input type="checkbox"/> Prophylaxis _____ / week <input type="checkbox"/> Immune tolerance: _____ <input type="checkbox"/> Breakthrough bleed: <input type="checkbox"/> Minor: _____ <input type="checkbox"/> Major: _____			<input type="checkbox"/> Thrombate III	Dose:	<input type="checkbox"/> Breakthrough bleed: <input type="checkbox"/> Minor: _____ <input type="checkbox"/> Major: _____		
<input type="checkbox"/> Humate P					Dose:	<input type="checkbox"/> Thrombate III			
<input type="checkbox"/> Wilate	IU/kg	<input type="checkbox"/> Prophylaxis _____ / week <input type="checkbox"/> Immune tolerance: _____ <input type="checkbox"/> Breakthrough bleed: <input type="checkbox"/> Minor: _____ <input type="checkbox"/> Major: _____			Concentrates of Antithrombotic Factors				
<input type="checkbox"/> BenefIX					Target	<input type="checkbox"/> Thrombate III	Target	Therapy Regimen: <input type="checkbox"/> Breakthrough bleed: <input type="checkbox"/> Minor: _____ <input type="checkbox"/> Major: _____	
<input type="checkbox"/> Mononine	IU/kg	<input type="checkbox"/> Prophylaxis _____ / week <input type="checkbox"/> Immune tolerance: _____ <input type="checkbox"/> Breakthrough bleed: <input type="checkbox"/> Minor: _____ <input type="checkbox"/> Major: _____			<input type="checkbox"/> Thrombate III	Dose:	<input type="checkbox"/> Breakthrough bleed: <input type="checkbox"/> Minor: _____ <input type="checkbox"/> Major: _____		
<input type="checkbox"/> Alphanine SD					Dose:	<input type="checkbox"/> Thrombate III			
<input type="checkbox"/> Bebulin VH	IU/kg	<input type="checkbox"/> Prophylaxis _____ / week <input type="checkbox"/> Immune tolerance: _____ <input type="checkbox"/> Breakthrough bleed: <input type="checkbox"/> Minor: _____ <input type="checkbox"/> Major: _____			Concentrates of Antithrombotic Factors				
<input type="checkbox"/> Bebulin VH					Dose:	<input type="checkbox"/> Thrombate III	Dose:		

Ancillary Supplies and Kits Provided as Needed for Administration.

PRODUCT SUBSTITUTION PERMITTED (Date) _____ DISPENSE AS WRITTEN (Date) _____