Hemophilia / Bleeding Disorders

Phone#: 877-778-0318 Fax#: 877-778-0399

Patient + Insurance Information

Patient Name: _____ DOB: _____ Sex: ☐ Male ☐ Female SSN: _____ Wt (kg/lbs): _____ Ht (cm/in): _____

Address: _____ Phone: _____ Alternate: _____

Caregiver Name: _____ Relation to Patient: _____ Phone: _____

Insurance Plan: _____ Plan ID: _____ BIN #: _____ PCN #: _____ GRP #: _____

Please fax a copy of the front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber Name: _____ DEA: _____ NPI: _____

Address: _____

Phone: _____ Alternate: _____ Fax: _____ Email: _____

If shipping to prescriber: ☐ First Fill ☐ Always ☐ Never

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis Code: _____ ☐ D66 (Type A – Factor VIII Deficiency) ☐ D67 (Type B – Factor IX Deficiency) ☐ D68.0 (Von Willebrand Disease – Check Type: ☐ 1 ☐ 2 ☐ 3)

Date of Diagnosis: _____ ☐ D68.1 (Type C – Factor XI Deficiency) ☐ D68.2 (Hereditary deficiency of other clotting factors) ☐ D68.311 (Acquired Hemophilia)

☐ D68.32 (Hemorrhagic disorder due to extrinsic circulating anticoagulants) ☐ Other: _____

Circulating Factor _____ % Target Joints: ☐ No ☐ Yes _____ Access: ☐ Peripheral Butterfly ☐ PICC ☐ Implant Port ☐ Broviac® / Hickman®

Severity: ☐ Severe (<1%) ☐ Moderate (1 - 5%) ☐ Mild (>5%) Protocol: ☐ Pre-Surgical ☐ Prophylaxis ☐ Immune Tolerance ☐ On-demand

Inhibitor Activity: ☐ None ☐ Historical ☐ Current _____ BU/mL Start Date: _____ End Date: _____

Comorbidities: _____

Concomitant Medications: _____

Allergies: ☐ NKDA ☐ Other: _____

Current Patient Need: ☐ STAT/Urgent bleed ☐ Ongoing care or Not urgent ☐ Procedure scheduled for: _____

Prescription

Therapy Regimen for Factor or Inhibitor Products	☐ Prophylaxis _____/week ☐ Target Dose: _____ IU/kg ☐ Dose: _____ IU ± _____ % (Assay variation) # Doses: _____ Refills: _____	☐ Breakthrough bleed: As Needed ☐ Minor: _____ ± _____ % ☐ Moderate: _____ ± _____ % ☐ Major: _____ ± _____ % # Doses: _____ Refills: _____	☐ Immune Tolerance: Frequency _____ ☐ Target Dose: _____ IU/kg ☐ Dose: _____ IU ± _____ % (Assay variation) # Doses: _____ Refills: _____
Factor VIII (Recombinant)	☐ Advate® ☐ Adynovate® ☐ Afstyla® ☐ Eloctate™ ☐ Jivi® ☐ Kogenate® FS ☐ Kovaltry® ☐ NovoEight® ☐ Nuwiq® ☐ Recombinate® ☐ Xyntha® ☐ Xyntha® Solofuse		
Factor VIII (Human)	☐ Hemofil® M		
Factor VIII (Human) + VWF	☐ Alphanate® SD ☐ Humate-P® ☐ Koāte® DVI ☐ Wilate®		
Factor IX (Recombinant)	☐ Alprolix® ☐ Benefix® RT ☐ Idelvion® ☐ Ixinity® ☐ Rebinyn® ☐ Rixubis®		
Factor IX (Human)	☐ AlphaNine® SD ☐ Mononine®		
Factor X (Human)	☐ Coagadex®		
Factor XIII (Human)	☐ Corifact®		
Anti-Inhibitor (Human)	☐ Feiba®		
Anti-Thrombin III (Human)	☐ Thrombate III®		
Protein C Concentrate (Recombinant)	☐ Ceprotin® ☐ Acute episode/short-term prophylaxis ☐ Initial dose: 100-120 IU/kg IV ☐ Subsequent 3 doses: 60-80 IU/kg IV every 6 hours ☐ Maintenance dose: 45-60 IU/kg IV every 6 or 12 hours ☐ Long-term prophylaxis: Maintenance dose: 45-60 IU/kg every 12 hours ☐ 500 IU ☐ 1000 IU Quantity: ☒ 1 month ☐ Other: _____ Refills: ☐ 1 year or as otherwise specified ☐ Other: _____		
Pro-Thrombin Complex (Human)	☐ Bebulin® VH ☐ Profilnine® SD		
Von Willebrand Factor (Recombinant)	☐ Vonvendi®		
Acquired Hemophilia A	☐ Obizur®		
Gene therapy	☐ Roctavian® (Hemophilia A) ☐ Hemgenix® (Hemophilia B)		
Factor XIII-A subunit (Recombinant)	☐ Tretten® 35 IU/kg SQ once monthly Quantity: ☒ 1 month ☐ Other: _____ Refills: ☐ 1 year or as otherwise specified ☐ Other: _____		

Revised: 4/3/2024

Medication	Strength	Dose & Direction	Quantity/Refills
☐ Altuviiio Factor VIII (Recombinant)	☐ 50 IU/kg ☐ _____ IU/kg	☐ Prophylaxis: 50 IU/kg IV once weekly ☐ On demand treatment: 50 IU/kg IV as needed for bleeding episodes. Contact your physician's office if bleeding does not resolve. ☐ Other: _____ Weight: _____ kg	Quantity: ☒ 1 month ☐ Other: _____ Refills: ☐ 1 year or as otherwise specified ☐ Other: _____
☐ Esperoct Factor VIII (Recombinant)	☐ _____ IU /kg	☐ Prophylaxis: ____ IU/kg IV every ___ days or ___ times per week ☐ On demand treatment: ____ IU/kg IV as needed for bleeding episodes. Contact your physician's office if bleeding does not resolve. ☐ On demand treatment: ____ IU/kg IV as needed for bleeding episodes. Contact your physician's office if bleeding does not resolve.	Quantity: ☒ 1 month Refills: ☐ 1 year or as otherwise specified ☐ Other: _____
☐ Hemlibra	☐ 30 mg/mL ☐ 60 mg/0.4 mL ☐ 105 mg/0.7 mL ☐ 150 mg/1 mL ☐ 300 mg/2 ml ☐ 12 mg/0.4mL	☐ Initial dose: 3 mg/kg subcutaneously once weekly for 4 weeks ☐ Maintenance dose: ☐ 1.5 mg/kg subcutaneously every week ☐ 3 mg/kg subcutaneously every 2 weeks ☐ 6 mg/kg subcutaneously every 4 weeks Weight: _____ kg	Quantity: ☒ 1 month ☐ Other: _____ Refills: ☐ 1 year or as otherwise specified ☐ Other: _____
☐ NovoSeven RT Factor VIIa (Recombinant)	☐ ____ mcg/kg	Infuse _____ mcg/kg slow IV push every _____ hours, and/or _____ _____ _____ Weight: _____ kg	Quantity: ☒ 1 month ☐ Other: _____ Refills: ☐ 1 year or as otherwise specified ☐ Other: _____
☐ SevenFact Anti-Inhibitor (Recombinant)	☐ 1 mg ☐ 5 mg	For Mild/Moderate bleeds: ☐ 75 mcg/kg IV, repeat q 3 hours until hemostasis achieved or ☐ Initial dose of 225 mcg/kg IV. May infuse 75 mcg/kg IV q 3 hours prn if hemostasis not achieved within 9 hours. For Severe bleeds: ☐ 225 mcg/kg IV, followed if necessary 6 hours later with 75 mcg/kg IV every 2 hours. ☐ Other_____ Round to nearest whole vial. Weight: _____ kg	Quantity: ☒ 1 month ☐ Other: _____ Refills: ☐ 1 year or as otherwise specified ☐ Other: _____

Flushing Protocol	☐ Sodium Chloride 0.9% 5-10 mL pre and post medications	☐ Heparin _____ units/mL	_____ mL as needed		
Ancillary Supplies	☒ Dispense infusion supplies as needed for proper administration and disposal.				
Skilled Nursing Visits	☒ All nursing services requirements to be completed per pharmacy protocol including teaching as needed.				
Other Medications	☐ Amicar®	☐ Tablet ☐ Syrup	Directions: _____	Qty: _____	Refills: _____
	☐ Lysteda®	Directions: _____		Qty: _____	Refills: _____
	☐ Stimate®	☐ 150mcg	☐ Wt < 50kg Single spray in one nostril	Qty: _____	Refills: _____
		☐ 300mcg	☐ Wt > 50kg Single spray in both nostrils	Qty: _____	Refills: _____
	☐ Anaphylaxis Order	☐ Epinephrine Pen 0.3mg (> 30kg) ☐ Epinephrine Pen 0.15mg (15-30kg) Directions: Use as directed for Anaphylaxis; may repeat in 5-10 minutes x 1		Qty: 2	Refills: _____

Prescriber's Signature: _____ Date: _____

I authorize AmeriPharma and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above.
I understand that I can revoke this designation at any time by providing written notice to AmeriPharma.