Hemophilia
REFERRAL FORM

FAX REFERRAL TO: +1(844) 277-0049 **PHONE:** +1(844) 650-5802

1 PATIENT'S INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ **DOB:** _____ **Gender:** ☐ MALE ☐ FEMALE
Address: _____ **City/State/Zip:** _____
Primary Phone: _____ **Email:** _____ **SSN:** _____ **Primary Language:** _____
Emergency Contact: _____ **Relationship to Patient:** _____ **Phone:** _____

2 INSURANCE *(Please attach **If Available** a copy of the Patient's' insurance card(s) Front/ Back)*

Primary Insurance: _____ **Policy No:** _____ **Group:** _____
Primary RX Insurance:_____ **ID No:**_____ **RX GRP:**_____ **RX BIN:**_____ **RX PCN:**_____

3 DIAGNOSIS AND CLINICAL INFORMATION

First time receiving Therapy? ☐ Yes ☐ No **If No, previous product used:** _____ **Last Dose Given:** _____

Diagnosis (ICD-10)**:**

☐ D66 Hereditary factor VIII deficiency
☐ D67 Hereditary factor IX deficiency
☐ D68.0 Von Willebrand's disease
☐ D68.311 Acquired hemophilia
☐ D68.318 Other hemorrhagic disorder due to intrinsic circulating anticoagulants, antibodies, or inhibitors
☐ D68.8 Other specified coagulation defects
☐ D68.9 Coagulation defect, unspecified
☐ D68.2 Hereditary deficiency of other clotting factors
☐ Other Code: _____ Description: _____

Patient Clinical Information:

Drug Allergies:_____ ☐ NKDA **Ht:** _____in/cm **Wt:** _____lbs/Kg

Baseline Factor Level: _____

Labs: Please fax copy of the following labs dated within 1 year of the patients referral request:
☐ **CMP** ☐ **CBC w/ diff** ☐ **Iron/TIBC panel** ☐ **Ferritin**

4 PRESCRIPTION INFORMATION

ACCESS: ☐ IV ☐ PORT

RX INFORMATION: Our pharmacist will identify clinically appropriate brand *(Unless product is specifically specified at the time of referral)* and infusion rate per FDA guidelines. Clinically appropriate substitutions may be allowed based on availability or payor requirements. Round dose(s) to the nearest vial size. Official orders will be outlined with "May Infuse" +/- 3 days if scheduling needs arises, with insurance payor approval".

PRODUCT: ☐ Humate-P ☐ Panhematin ☐ Other: _____

DOSE & DIRECTIONS

☐ **Prophylaxes:** _____

☐ **On Demand Treatment:**
Infuse _____ units (+/- 10%) slow IV push every _____ hours / days (circle one) for a total of _____ doses as needed for bleeding episodes.

☐ **Minor Bleed:** _____IU IV q _____ hr PRN

☐ **Major Bleed:** _____IU IV q _____ hr PRN

☐ **Immune Tolerance:** _____

☐ **Other:** _____

ANAPHYLAXIS PROTOCOL:

MEDICATION	DIRECTION	QUANTITY	REFILLS
☒ EPINEPHRINE **(vial or autoinjector)**	Administer IM for severe anaphylactic reaction. May repeat in 5-15 minutes ☐ ***0.3 mg (Wt > 30 kg)*** ☐ ***0.15 mg (Wt 15-30 kg)*** ☐ ***0.1 mg (Wt 7.5-15 kg)***	Quantity: **(x1) Vial** or **(x2) Pen(s)**	Refills: **PRN**
☒ DIPHENHYDRAMINE **(50mg/mL)**	Administer via IM or slow IV push for severe anaphylactic reaction. ☐ ***50 mg (Wt > 30 kg)*** ☐ ***25 mg (Wt 15-30 kg)*** ☐ ***12.5mg (Wt 7.5-15kg)***	Quantity: **(x1) Vial(s)**	Refills: **PRN**

NURSING/ LABS/ INFUSION SUPPLIES:

☒ **NURSING:** Nursing visits with each infusion to establish venous access, administer medication, assess and monitor patient, provide education, and complete lab draws.

☒ **INFUSION SUPPLIES:** Diluent, infusion supplies, and infusion pump PRN for the reconstitution, administration, and disposal of medication.

☒ **FLUSHING PROTOCOL:** Sodium chloride 0.9%, up to 10 mL before/after medication, and/or PRN to maintain patency.
☐ Heparin: ☐ 10 Units/mL ☐ 100 Units/mL, _____ as final flush and/or PRN to maintain patency

☒ **LABS:** [Dx code: Z79.899, Other long term (current) drug therapy]. **Note**: *Samples are time sensitive once drawn.*
Labs to be drawn every _____ months prior to administration: ☐ CBC w/ diff ☐ CMP ☐ Iron/TIBC panel ☐ Ferritin.

5 PRESCRIBER INFORMATION

Prescriber Name: _____ **Title:** ☐ MD ☐ DO ☐ ND ☐ PA ☐ APRN **NPI:** _____
Address: _____ **City/State/Zip:** _____
Phone: _____ **Fax:** _____ **Contact Person:** _____

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record.
I authorize IV Solutions RX and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future refills of the same prescription for the patient listed above. I understand that I can revoke the designation at any time by providing written notice to IV Solutions RX.

Prescribers Signature **Date**

THANK YOU FOR YOU TRUSTING US IN YOUR PATIENTS SPECIALTY CARE

#welcome to our family