

# 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):

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

### 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
<input checked="" type="checkbox"/> EPINEPHRINE (vial or autoinjector)	Administer IM for severe anaphylactic reaction. May repeat in 5-15 minutes <input type="checkbox"/> 0.3 mg (Wt > 30 kg) <input type="checkbox"/> 0.15 mg (Wt 15-30 kg) <input type="checkbox"/> 0.1 mg (Wt 7.5-15 kg)	Quantity: (x1) Vial OR (x2) Pen(s)	Refills: PRN
<input checked="" type="checkbox"/> DIPHENHYDRAMINE (50mg/mL)	Administer via IM or slow IV push for severe anaphylactic reaction. <input type="checkbox"/> 50 mg (Wt > 30 kg) <input type="checkbox"/> 25 mg (Wt 15-30 kg) <input type="checkbox"/> 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 SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

Prescriber Name: \_\_\_\_\_ Title:  MD  DO  ND  PA  APRN NPI: \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Contact Person: \_\_\_\_\_

- DISPENSE AS WRITTEN  BRAND MEDICALLY NECESSARY  DO NOT SUBSTITUTE  May Substitute /  Product Selection Permitted /  Substitution Permissible  
 NO SUBSTITUTION /  DAW /  MAY NOT SUBSTITUTE

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution." NY & IA: electronic prescription required.

Prescribers are to comply with state-specific prescription regulations, which may include requirements for electronic prescribing, generic substitution, authorized prescription formats, and fax language. Noncompliance with these requirements may prompt follow-up communication with the prescriber.

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.

**CONFIDENTIALITY NOTICE:** The information contained in this transmission may contain confidential information, including patient information protected by federal and state privacy laws. It is intended only for the use of the person(s) named above. If not the intended recipient, you are hereby notified that any review, dissemination, distribution, or duplication of this communication is strictly prohibited. If you are not the intended recipient, please contact the sender by reply email to [info@ivsolutionsrx.com](mailto:info@ivsolutionsrx.com) and destroy all copies of the original message.

THANK YOU FOR YOU TRUSTING US WITH YOUR PATIENTS SPECIALTY CARE

#welcome to our family