Bleeding Disorders

Rx International Pharmacy

Phone: (305) 221-1421
Fax: (305) 221-3275

Patient Information

Patient Name: _____ DOB: _____
Sex: ❑ Female ❑ Male SS #: _____
1˚ Language: _____ Wt:_____ ❑ kg ❑ lbs Ht:_____ ❑ cm ❑ in
Address: _____
Apt/Suite: _____ City:_____ State:_____ Zip:_____
Phone:_____ Alternate Phone:_____
Caregiver name: _____ Relation: _____
Local Pharmacy: _____ Phone: _____

Prescriber + Shipping Information

Physician Name:_____
NPI #: _____
Address: _____ _____
Apt/Suite: _____ City:_____ State:_____ Zip:_____
Contact: _____
Phone: _____ Alternate: _____
Fax: _____
Email address: _____
If shipping to physician: ❑ 1st Fill ❑ Always ❑ Never

Insurance Information (Please fax a copy of front and back of the insurance cards)

1˚ Insurance Plan: _____ Plan ID # _____ Policy Holder: _____ Relation: _____
2˚ Insurance Plan: _____ Plan ID # _____ Policy Holder: _____ Relation: _____

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

ICD-10/Diagnosis Code:

❑ D67 (Type B – Factor IX Deficiency)
❑ D68.2 (Hereditary deficiency of other clotting factors)
❑ D68.4 (Acquired coagulation factor deficiency)
❑ _____
Date of Diagnosis: _____
Circulating Factor _____% Target Joints: ❑ No ❑ Yes _____
Severity: ❑ Severe (<1%) ❑ Moderate (1 - 5%) ❑ Mild (>5%)
Inhibitor Activity: ❑ None ❑ Historical ❑ Current _____BU/mL

❑ D66 (Type A – Factor VIII Deficiency)
❑ D68.1 (Type C – Factor XI Deficiency)
❑ D68.32 (Hemorrhagic disorder due to extrinsic circulating anticoagulants)
❑ D68.0 (Von Willebrand Disease – Check Type:❑ 1 ❑ 2 ❑ 3)

Access: ❑ Peripheral Butterfly ❑ PICC ❑ Implant Port ❑ Broviac®/Hickman®
Protocol: ❑ Pre-Surgical ❑ Prophylaxis ❑ Immune Tolerance ❑ On-demand
Start Date: _____ End Date: _____

Comorbidities: _____
Concomitant Medications: _____
Allergies: ❑ NKDA ❑ Other: _____

Prescription

Factor VIIa (Recombinant)	❑ NovoSeven® RT			
Factor VIII (Recombinant)	❑ Advate®	❑ Adynovate®	❑ Eloctate™	❑ Helixate® FS
	❑ Kogenate® FS	❑ NovoEight®	❑ Recombinate®	❑ Xyntha®
Factor VIII (Human)	❑ Hemofil® M	❑ Monclate-P®	❑ Nuwiq®	
Factor VIII (Human) + VWF	❑ Alphanate® SD	❑ Humate-P®	❑ Koāte® DVI	❑ Wilate®
Factor IX (Recombinant)	❑ Alprolix®	❑ Benefix® RT	❑ Ixinity®	❑ Rixubis®
Factor IX (Human)	❑ AlphaNine® SD	❑ Mononine®		
Factor X (Human)	❑ Coagadex®			
Factor XIII (Human)	❑ Corifact®			
VWF (Recombinant)	❑ Vonvendi™			
Anti-Inhibitor (Human)	❑ Feiba®			
Pro-Thrombin Complex (Human)	❑ Bebulin® VH	❑ Profilnine® SD		
Therapy Regimen for Factor or Inhibitor Products	❑ Prophylaxis _____/week ❑ Target Dose: _____ IU/kg ❑ Dose: _____ IU ± ____% (Assay variation) # Doses: _____ Refills: _____	❑ Breakthrough bleed ❑ Minor: _____IU ± ____% ❑ Moderate: _____IU ± ____% ❑ Major: _____IU ± ____% # Doses: _____ Refills: _____	❑ Immune Tolerance ❑ Target Dose: _____ IU/kg ❑ Dose: _____ IU ± ____% (Assay variation) # Doses: _____ Refills: _____	
Flushing Protocol	❑ Sodium Chloride 0.9% 5-10 mL pre and post medications	❑ Heparin _____Units/mL _____mL as needed		
Ancillary Supplies	❑ As needed for proper administration and disposal of medication			
Skilled Nursing Visits	❑ As needed for IV access, administration and proper clinical monitoring			

All nursing services requirements to be completed per pharmacy protocol.

Other Medications	❑ Amicar®	Directions: _____ Qty: _____ Refills:_____
	❑ Lysteda®	Directions: _____ Qty: _____ Refills:_____
	❑ Stimate®	Directions: _____ Qty: _____ Refills:_____
	❑ _____	Directions: _____ Qty: _____ Refills:_____

Prescription will be filled with generic (if available) unless prescriber writes "DAW" (dispense as written): _____

Prescriber's Signature:_____ Date: _____

I authorize Rx International Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.