



Patient Information

Patient Name: _____ DOB: _____
 Sex: Female Male SS #: _____
 1st 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)

1st Insurance Plan: _____ Plan ID #: _____ Policy Holder: _____ Relation: _____
 2nd 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) D66 (Type A – Factor VIII Deficiency)
 D68.2 (Hereditary deficiency of other clotting factors) D68.1 (Type C – Factor XI Deficiency)
 D68.4 (Acquired coagulation factor deficiency) D68.32 (Hemorrhagic disorder due to extrinsic circulating anticoagulants)
 _____ D68.0 (Von Willebrand Disease – Check Type: 1 2 3)
 Date of Diagnosis: _____
 Circulating Factor _____% Target Joints: No Yes _____
 Severity: Severe (<1%) Moderate (1 - 5%) Mild (>5%)
 Inhibitor Activity: None Historical Current _____ BU/mL
 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) | <input type="checkbox"/> NovoSeven® RT | | |
| Factor VIII (Recombinant) | <input type="checkbox"/> Advate® | <input type="checkbox"/> Adynovate® | <input type="checkbox"/> Eloctate™ |
| | <input type="checkbox"/> Kogenate® FS | <input type="checkbox"/> NovoEight® | <input type="checkbox"/> Recombinate® |
| Factor VIII (Human) | <input type="checkbox"/> Hemofil® M | <input type="checkbox"/> Monclate-P® | <input type="checkbox"/> Nuwiq® |
| Factor VIII (Human) + VWF | <input type="checkbox"/> Alphanate® SD | <input type="checkbox"/> Humate-P® | <input type="checkbox"/> Koāte® DVI |
| Factor IX (Recombinant) | <input type="checkbox"/> Alprolix® | <input type="checkbox"/> Benefix® RT | <input type="checkbox"/> Ixinity® |
| Factor IX (Human) | <input type="checkbox"/> AlphaNine® SD | <input type="checkbox"/> Mononine® | <input type="checkbox"/> Rixubis® |
| Factor X (Human) | <input type="checkbox"/> Coagadex® | | |
| Factor XIII (Human) | <input type="checkbox"/> Corifact® | | |
| VWF (Recombinant) | <input type="checkbox"/> Vonvendi™ | | |
| Anti-Inhibitor (Human) | <input type="checkbox"/> Feiba® | | |
| Pro-Thrombin Complex (Human) | <input type="checkbox"/> Bebulin® VH | <input type="checkbox"/> Profilnine® SD | |
| Therapy Regimen for Factor or Inhibitor Products | <input type="checkbox"/> Prophylaxis _____/week | <input type="checkbox"/> Breakthrough bleed | <input type="checkbox"/> Immune Tolerance |
| | <input type="checkbox"/> Target Dose: _____ IU/kg | <input type="checkbox"/> Minor: _____ IU ± _____% | <input type="checkbox"/> Target Dose: _____ IU/kg |
| | <input type="checkbox"/> Dose: _____ IU ± _____% (Assay variation) | <input type="checkbox"/> Moderate: _____ IU ± _____% | <input type="checkbox"/> Dose: _____ IU ± _____% (Assay variation) |
| | # Doses: _____ Refills: _____ | <input type="checkbox"/> Major: _____ IU ± _____% | # Doses: _____ Refills: _____ |
| Flushing Protocol | <input type="checkbox"/> Sodium Chloride 0.9% 5-10 mL pre and post medications | <input type="checkbox"/> Heparin _____ Units/mL _____ mL as needed | |
| Ancillary Supplies | <input type="checkbox"/> As needed for proper administration and disposal of medication | | |
| Skilled Nursing Visits | <input type="checkbox"/> As needed for IV access, administration and proper clinical monitoring | | |

All nursing services requirements to be completed per pharmacy protocol.

| | | | | |
|--------------------------|-----------------------------------|-------------------|------------|----------------|
| Other Medications | <input type="checkbox"/> Amicar® | Directions: _____ | Qty: _____ | Refills: _____ |
| | <input type="checkbox"/> Lysteda® | Directions: _____ | Qty: _____ | Refills: _____ |
| | <input type="checkbox"/> Stimate® | Directions: _____ | Qty: _____ | Refills: _____ |
| | <input type="checkbox"/> _____ | 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.

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