

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:

Date of Diagnosis: _____ D67 (Type B – Factor IX Deficiency) D68.2 (Hereditary deficiency of other clotting factors) D68.0 (Von Willebrand Disease – Check Type: 1 2 3)
 D66 (Type A – Factor VIII Deficiency) D68.1 (Type C – Factor XI Deficiency) D68.32 (Hemorrhagic disorder due to extrinsic circulating anticoagulants) _____
 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: _____

Prescription

Factor VIIa (Recombinant)	<input type="checkbox"/> NovoSeven® RT
Factor VIII (Recombinant)	<input type="checkbox"/> Advate® <input type="checkbox"/> Afstyla® <input type="checkbox"/> Helixate® FS <input type="checkbox"/> Kovaltry® <input type="checkbox"/> Nuwiq® <input type="checkbox"/> Xyntha® <input type="checkbox"/> Adynovate® <input type="checkbox"/> Elocate™ <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®
Factor VIII (Human) + VWF	<input type="checkbox"/> Alphanate® SD <input type="checkbox"/> Humate-P® <input type="checkbox"/> Koate® DVI <input type="checkbox"/> Wilate®
Factor IX (Recombinant)	<input type="checkbox"/> Alprolix® <input type="checkbox"/> Benefix® RT <input type="checkbox"/> Idelvion® <input type="checkbox"/> Ixinity® <input type="checkbox"/> Rebinyn® <input type="checkbox"/> Rixubis®
Factor IX (Human)	<input type="checkbox"/> AlphaNine® SD <input type="checkbox"/> Mononine®
Factor X (Human)	<input type="checkbox"/> Coagadex®
Factor XIII (Human)	<input type="checkbox"/> Corifact®
Anti-Inhibitor (Human)	<input type="checkbox"/> Feiba®
Anti-Thrombin III (Human)	<input type="checkbox"/> Thrombate III®
Protein C Concentrate (Recombinant)	<input type="checkbox"/> Ceprotein®
Pro-Thrombin Complex (Human)	<input type="checkbox"/> Bebulin® VH <input type="checkbox"/> Profilnine® SD
Von Willebrand Factor (Recombinant)	<input type="checkbox"/> Vonvendi®
Hemlibra®	<input type="checkbox"/> 30mg/ml <input type="checkbox"/> 60mg/0.4ml <input type="checkbox"/> Initial dose: 3mg/kg SQ once weekly for 4 weeks
	<input type="checkbox"/> 105mg/0.7ml <input type="checkbox"/> 150mg/1ml <input type="checkbox"/> Maintenance dose: 1.5mg/kg SQ once weekly Wt: _____ kg
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: _____ ± _____% <input type="checkbox"/> Target Dose: _____ IU/kg
	<input type="checkbox"/> Dose: _____ IU ± _____% <input type="checkbox"/> Moderate: _____ ± _____% <input type="checkbox"/> Dose: _____ IU ± _____%
	(Assay variation) <input type="checkbox"/> Major: _____ ± _____% (Assay variation)
# Doses: _____ Refills: _____	# Doses: _____ Refills: _____
# Doses: _____ Refills: _____	# 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	<input type="checkbox"/> Amicar® <input type="checkbox"/> Tablet <input type="checkbox"/> Syrup	Directions: _____	Qty: _____	Refills: _____
	<input type="checkbox"/> Lysteda®	Directions: _____	Qty: _____	Refills: _____
	<input type="checkbox"/> Stimate®	<input type="checkbox"/> 150mcg <input type="checkbox"/> Wt < 50kg Single spray in one nostril	Qty: _____	Refills: _____
	<input type="checkbox"/> _____	<input type="checkbox"/> 300mcg <input type="checkbox"/> Wt > 50kg Single spray in both nostrils	Qty: _____	Refills: _____
<input type="checkbox"/> _____	Directions: _____	Qty: _____	Refills: _____	

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: _____

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.

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