

BLEEDING DISORDERS REFERRAL FORM

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Toll Free: 866-317-0672

Today's Date

CURRENT PATIENT
 NEW PATIENT

FEB 2018

Patient Name _____ SS# _____ DOB _____
Address _____ Apt # _____ Male Female
City _____ State _____ Zip _____ Daytime Tel _____ Cell _____
Email _____
Ship to Patient at Home Work OR Patient will pick up at Physician Office Pharmacy Date Needed _____

D66 Hereditary Factor VIII Deficiency D67 Hereditary Factor IX Deficiency
 D68.1 Hereditary Factor XI Deficiency D68.2 Hereditary Deficiency of other Clotting Factors
 D68.0 von Willebrand Disease D68.4 Acquired Coagulation Factor Deficiency
 D68.9 Coagulation Defect, Unspecified Other ICD-10 _____

Description _____
Baseline factor percent _____ Target joint(s) No Yes _____ Inhibitor: No History Current _____ BU/ml
Inhibitor protocol _____

DNR/Advance directive status: Received N/A Hep B, Hep C, HIV or TB positive? (circle) Date chest x-ray _____
Allergies _____ Comorbidities _____

Current Medications (if necessary, please fax a complete list) _____
Vascular access: Peripheral Port Other Weight _____ kg lbs Height _____ cm in

Insured's Name _____ Relation to Patient _____
Eligible for Medicare Yes No If yes, Medicare# _____ Prescription Card Yes No If Yes, Carrier _____
Tel _____ Fax _____ Policy/Group# _____
Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

Prescriber's Name _____ Office Contact _____
Street Address _____ Suite# _____ City _____ State _____ Zip _____
Tel _____ Fax _____ Email _____
License# _____ NPI# _____ UPIN# _____ DEA# _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

EpiPen Adult (0.3 mg) as directed for reactions, qty:1 EpiPen Jr (0.15 mg) as directed for reactions, qty:1
Factor VIII recombinant: Advate Helixate FS Kogenate FS Recombinate Xyntha Other: _____
Plasma derived: Hemofil M Monoclate-P Other _____
Approximate units and directions: _____ Dispense qty: _____ Refills: _____
Factor VIII and von Willebrand plasma derived: Alphanate Humate-P Koate-DVI Wilate Other: _____
Approximate units VWF Factor VIII and directions: _____ Dispense qty: _____ Refills: _____
Factor IX recombinant: BeneFix Alprolix Rixubis Other _____
Plasma derived: AlphaNine SD Mononine Other: _____
Approximate units and directions: _____ Dispense qty: _____ Refills: _____
Factor VII recombinant: NovoSeven RT Other _____
Dose (mg) and direction: _____ Dispense qty: _____ Refills: _____
Activated Prothrombin Complex Concentrates plasma derived: Feiba VH Other _____
Approximate units and directions: _____ Dispense qty: _____ Refills: _____
Prothrombin Complex Concentrates plasma derived: Bebulin VH Profilnine SD Other _____
Approximate units and directions: _____ Dispense qty: _____ Refills: _____
Stimate 1 spray in one nostril each nostril _____ Dispense qty: _____ Refills: _____
Amicar syrup 500/1000 mg tab Dose and directions: _____ Dispense qty: _____ Refills: _____
Other (continuous infusion, Rituxan, vancomycin, etc): _____

Line care: Sodium chloride 0.9% 5-10ml 3-5 ml Heparin (10 units/ml 100 units/ml) Other: _____
 Apply 30-60 minutes prior to access (Emla 30 gram LMX 30 gram) Other: _____
Nursing orders: Skilled nurse to infuse/teach mixing infusion, self-monitoring, other aspects of care _____
Lab orders: _____
Supplies: All infusion and prevention supplies as needed and/or: _____

By signing this form and utilizing our services, you are authorizing Elwyn Specialty Care and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) _____ **Date** _____

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Please fax completed referral form to **Elwyn Specialty Care** at **610-545-6030** Visit **www.ELWYNSPECIALTYCARE.com** for online fillable forms.