

Hemophilia Order Form

Fax Completed Form To:

Phone:

PATIENT INFORMATION			
Patient Name:		Date of Birth:	Referral Date:
Address:		City/State/Zip:	
Home Phone:	Cell Phone:		Work Phone:
Secondary Contact:	Height:	Weight:	☐ Male ☐ Female
Patient Diagnosis & ICD-10:			
Allergies:			
PROVIDER INFORMATION			
Physician Name:		Lic.#:	DEA #:
Practice Name:		NPI#:	
Address:		City/State/Zip:	
Office Contact:	Phone:		Fax:
Supervisory Physician (if applicable):			
PLEASE ATTACH			
☐ Patient demographics & front/back copy of all insurance cards (prescription & medical) ☐ Recent office visit notes, history & physical, lab and pertinent procedure results ☐ Current medication list & list of prior medications tried and failed (with dates) ☐ Inhibitor history, if applicable		☐ Line access documentation/verification, if applicable ☐ Vaccine status (any vaccination) and documentation of any recent vaccinations ☐ Letter of medical necessity if drug dosing or indication is outside of FDA guidelines	
DIAGNOSIS (ICD-10)			
☐ D66 Hereditary factor VIII deficiency, Hemophilia A ☐ D67 Hereditary factor IX deficiency, Hemophilia B ☐ D68.0 Von Willebrand's disease, unspecified		☐ D68.311 Acquired hemophilia ☐ D68.318 Other hemorrhagic disorder due to intrinsic circulating anticoagulants, antibodies, or inhibitors ☐ D68.8 Other specified coagulation defects	
☐ D68.9 Coagulation defect, unspecified ☐ D68.2 Hereditary deficiency of other clotting factors ☐ Other Code: _____ Description: _____			
PRODUCT	PRESCRIPTION INFORMATION		REFILLS
Is this a first dose? ☐ Yes ☐ No If No, when was last dose given? _____ When is patient due for next dose? _____			
Baseline Factor Level: _____ ☐ Severe ☐ Moderate ☐ Mild			
Weight _____ kg Date _____ (current weight must be entered for valid prescription)			
Hemophilia A	☐ Advate ☐ Adynovate ☐ Alphanate ☐ Altuviiro ☐ Eloctate ☐ Esperoct ☐ Hemlibra ☐ Jivi ☐ Kovaltry ☐ Novoeight ☐ Novoseven ☐ Nuwiq ☐ Sevenfact ☐ Wilate ☐ Xyntha ☐ Other _____		QUANTITY (# of doses) _____ ☐ 1 month ☐ Other _____
Hemophilia B	☐ Alphanine ☐ Benefix ☐ Idelvion ☐ Novoseven ☐ Rixubis ☐ Sevenfact ☐ Other _____		
Von Willebrand Disease	☐ Humate-P ☐ Vonvendi ☐ Wilate ☐ Other _____		
Other Bleeding Disorder	☐ Other _____		
Factor dose:	☐ Prophylaxis: Administer ☐ units/kg ☐ _____ IU IV every _____ (frequency) ☐ On demand treatment: ☐ Minor Bleed Administer ☐ units/kg ☐ _____ IU IV every _____ hours PRN ☐ Major Bleed Administer ☐ units/kg ☐ _____ IU IV every _____ hours PRN ☐ Administer ☐ units/kg ☐ _____ IU IV every _____ hours / ☐ days for a total of _____ doses as needed for bleeding episodes. Contact prescriber if bleeding dose not resolve ☐ Other _____		REFILLS ☐ 1 month ☐ Other _____
Hemlibra	Inject subcutaneously ☐ 1.5 mg/kg weekly ☐ 3 mg/kg every other week ☐ 6mg/kg monthly		
Nursing Orders: Nurse to provide assessment, lab draws, medication administration and vascular access device insertion and/or management per physician order IV Access type: ☐ Peripheral ☐ PICC line ☐ Port ☐ CVAD (Central Venous Access Device) ☐ Subcutaneous injection Supply Orders: All supplies for vascular access line care, and/or subcutaneous drug administration kits. Pump and IV pole will be provided as necessary Flush Orders: ☐ 0.9%NaCl 10ml flush pre- and post-infusion and as needed Heparin ☐ 10units/ml ---OR--- ☐ 100units/ml 5ml flush if indicated to maintain line Lab Orders: ☐ CBC, CMP ☐ Hepatitis/ HIV statu ☐ Iron Levels *Other _____ Frequency _____ Anaphylaxis Order: ☐ (Nursing to call MD if patient has anaphylactic reaction) Epinephrine 0.3mg IM x1, Diphenhydramine 50mg IVP x1 (PEDS 0.01mg/mL IM), may be repeated after 15 minutes as needed for severe reaction ☐ 2 mg Cathflo as needed - allow to dwell in catheter for up to 2 hours; second dose if remains occluded Site of Care: ☐ MD office ☐ Infusion clinic ☐ Home ☐ Other _____			

Prescriber's Signature
Dispense as Written

Print Name

Date

Prescriber's Signature
Substitution Permitted

Print Name

Date

