ameripharma SPECIALTY CARE

Hemophilia / Bleeding Disorders

Phone#: 877-778-0318 Fax#: 877-778-0399

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)	☐ NovoSeven® RT					
Factor VIII (Recombinant)	☐ Advate®	☐ Afstyla®	☐ Helixate® FS	☐ Kovaltry®	☐ Nuwiq®	☐ Xyntha®
	☐ Adynovate®	☐ Eloctate™	☐ Kogenate® FS	☐ NovoEight®	☐ Recombinate®	
Factor VIII (Human)	☐ Hemofil® M	☐ Monclate-P®				
Factor VIII (Human) + VWF	☐ Alphanate® SD	☐ Humate-P®	☐ Koāte® DVI	☐ Wilate®		
Factor IX (Recombinant)	☐ Alprolix®	☐ Benefix® RT	☐ Idelvion®	☐ Ixinity®	☐ Rebinyn®	☐ Rixubis®
Factor IX (Human)	☐ AlphaNine® SD	☐ Mononine®				
Factor X (Human)	☐ Coagadex®					
Factor XIII (Human)	☐ Corifact®					
Anti-Inhibitor (Human)	☐ Feiba®					
Anti-Thrombin III (Human)	☐ Thrombate III®					
Protein C Concentrate (Recombinant)	☐ Ceprotein®					
Pro-Thrombin Complex (Human)	☐ Bebulin® VH	☐ Profilnine® SD				
Von Willebrand Factor (Recombinant)	☐ Vonvendi®					
Hemlibra®	☐ 30mg/ml	☐ 60mg/0.4ml	☐ Initial dose: 3mg/kg SQ once weekly for 4 weeks			
	☐ 105mg/0.7ml	☐ 150mg/1ml	☐ Maintenance dose: 1.5mg/kg SQ once weekly Wt: _____kg			

Therapy Regimen for Factor or Inhibitor Products	☐ Prophylaxis _____/week ☐ Target Dose: _____ IU/kg ☐ Dose: _____ IU ± _____% (Assay variation) # Doses: _____ Refills: _____	☐ Breakthrough bleed ☐ Minor: _____ ± _____% ☐ Moderate: _____ ± _____% ☐ Major: _____ ± _____% # 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®	☐ Tablet ☐ Syrup	Directions: _____	Qty: _____	Refills: _____
	☐ Lysteda®		Directions: _____	Qty: _____	Refills: _____
	☐ Stimate®	☐ 150mcg	☐ Wt < 50kg Single spray in one nostril	Qty: _____	Refills: _____
		☐ 300mcg	☐ Wt > 50kg Single spray in both nostrils	Qty: _____	Refills: _____
	☐ _____		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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