Hemophilia & Bleeding Disorders Referral Form

Date: _____

Y Medical Associates
Fax: 914-747-1170
Phone: 855-747-1150

YMedical ASSOCIATES

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____

Date of Birth: _____ Gender: ☐ M ☐ F

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA#: _____ NPI#: _____
Contact Person: _____

INSURANCE INFORMATION *(Please attach the front and back of insurance and prescription drug card)*

Primary Insurance: _____ ID#: _____ Group: _____
Secondary Insurance: _____ ID#: _____ Group: _____
Prescription Card: _____ ID#: _____ BIN: _____ PCN: _____ Group: _____

DIAGNOSIS

☐ D66 HemophiliaA(FactorVIII deficiency)
☐ D67 Hemophilia B (Factor IX deficiency)
☐ D68.1 HemophiliaC(FactorXI deficiency)
☐ D68.2 Hereditary Deficiency of other clotting factors
☐ D68.01 VWD Type 1
☐ D68.02 VWD Type 2___
☐ D68.03 VWD Type 3
☐ D69.9 Hemorrhagic Condition,Unspecified
☐ D68.4 Acquired Coagulation Factor Deficiency
☐ D68.8 Other Specified Coagulation Defects
☐ Other: _____

PATIENT EVALUATION

Severity:

☐ Severe(<1%activity) ☐Moderate(1-5% activity) ☐ Mild (>5% activity)

- PatientWeight:_____Kg/Lbs Height:_____Inches/CM
- Allergies: _____
- Access:☐Port ☐PICC ☐PIV ☐ Butterfly ☐Other: _____
- Nursing Coordination:
  - Pharmacy to coordinate home health nursing visit as necessary: ☐Yes ☐ No

PRESCRIPTION INFORMATION

Medication		Directions	Quantity	Refills
☐ Advate ☐ Adynovate ☐ Afstyla ☐ Alphanate ☐ Eloctate ☐ Hemofil-M ☐ Jivi ☐ Koate ☐ Kovaltry ☐ NovoEight ☐ Nuwiq ☐ Recombinate ☐ Xyntha	☐ Alprolix ☐ Alphanine SD ☐ BeneFIX RT ☐ Idelvion ☐ Ixinity ☐ Mononine ☐ Rixubis ☐ Humate-P ☐ Vonvendi ☐ Wilate ☐ Feiba NF ☐ Novoseven RT	☐ ***Prophylaxis*** • Infuse_____Units (+/-10%) slow iv-push every _____ ☐ ***Breakthrough Bleed*** • Infuse_____Units (+/-10%) slow iv-push every _____hours/days (circle one) for a total of_____doses As Needed for bleeding episodes. Minor: ☐_____IU every_____hour/day PRN Major: ☐_____IU every_____hour/day PRN ☐ ***Other:*** _____	☐ 1month ☐ 3month ☐ Specify _____	☐ 1 Year ☐ Other _____
☐ Hemlibra	**Initial Dose:** ☐ 3-mg/kg OR ☐ _____ mg/kg once weekly for 4 weeks **Subsequent Dose:** ☐ 1.5-mg/kg q week ☐ 3-mg/kg q 2 weeks ☐ 6-mg/kg q 4 weeks _____mg/kg q ___ weeks	**Quantity of Vials:** ☐ ___30mg/mL ☐ ___60mg/0.4mL ☐ ___105mg/0.7mL ☐ ___150mg/mL		

☐ AmicarTablet/Syrup Directions:_____Qty:_____Refill _____

IV Access Flush Order: NaCl 0.9% 5-10ml IV before and after infusion, Heparin 10 Units/ml 5ml after infusion for PICC/Midline, Heparin 10 Units/ml 3ml after infusion for PIV, Heparin 100 Units/ml 5ml IV after infusion for PORT, All infusion supplies necessary to administer the medication

PrescriberSignature:_____ **Date:** _____