

**Hemophilia & Bleeding Disorders
Referral Form**

Y Medical Associates
Fax: 855-838-0623
Phone: 800-447-7558



Date: _____

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 Hemophilia A (Factor VIII deficiency)
- D67 Hemophilia B (Factor IX deficiency)
- D68.1 Hemophilia C (Factor XI deficiency)
- D68.2 Hereditary Deficiency of other clotting factors
- 68.0 von Willebrand Disease
- 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)

- Patient Weight: _____ 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
<input type="checkbox"/> Advate <input type="checkbox"/> Adynovate <input type="checkbox"/> Afstylia <input type="checkbox"/> Alphanate <input type="checkbox"/> Eloctate <input type="checkbox"/> Hemofil-M <input type="checkbox"/> Jivi <input type="checkbox"/> Koate <input type="checkbox"/> Kovaltry <input type="checkbox"/> NovoEight <input type="checkbox"/> Nuwiq <input type="checkbox"/> Recombinate <input type="checkbox"/> Xyntha	<input type="checkbox"/> Alprolix <input type="checkbox"/> Alphanine SD <input type="checkbox"/> BeneFIX RT <input type="checkbox"/> Idelvion <input type="checkbox"/> Ixinity <input type="checkbox"/> Mononine <input type="checkbox"/> Rixubis <input type="checkbox"/> Humate-P <input type="checkbox"/> Vonvendi <input type="checkbox"/> Wilate <input type="checkbox"/> Feiba NF <input type="checkbox"/> Novoseven RT	<input type="checkbox"/> Prophylaxis • Infuse _____ Units (+/-10%) slow iv-push every _____ <input type="checkbox"/> Breakthrough Bleed • Infuse _____ Units (+/-10%) slow iv-push every _____ hours/days (circle one) for a total of _____ doses As Needed for bleeding episodes. Minor: <input type="checkbox"/> _____ units every _____ hour/day PRN Major: <input type="checkbox"/> _____ units every _____ hour/day PRN <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 month <input type="checkbox"/> 3 month <input type="checkbox"/> Specify _____ <input type="checkbox"/> 1 Year <input type="checkbox"/> Other _____
<input type="checkbox"/> Hemlibra	Initial Dose: <input type="checkbox"/> 3-mg/kg OR <input type="checkbox"/> _____ mg/kg once weekly for 4 weeks Subsequent Dose: <input type="checkbox"/> 1.5-mg/kg q week <input type="checkbox"/> 3-mg/kg q 2 weeks <input type="checkbox"/> 6-mg/kg q 4 weeks _____ mg/kg q _____ weeks	Quantity of Vials: <input type="checkbox"/> _____ 30mg/mL <input type="checkbox"/> _____ 60mg/0.4mL <input type="checkbox"/> _____ 105mg/0.7mL <input type="checkbox"/> _____ 150mg/mL	

Amicar Tablet/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

Prescriber Signature: _____ **Date:** _____