Bleeding Disorders Referral Form

Date_____

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

YMedical ASSOCIATES

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
All Phone: _____
Caregiver name (if minor): _____
Date of Birth: _____ **Gender:** ☐ M ☐ F

PRESCRIBER INFORMATION

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

INSURANCE INFORMATION (*or fax copy of front and back of insurance and prescription drug cards*)

Primary Insurance:_____ ID#:_____ Group:_____ Phone:_____
Secondary Ins:_____ ID#:_____ Group: _____Phone:_____
Prescription Ins:_____ ID#:_____ BIN:_____ PCN:_____ Phone_____

DIAGNOSIS

☐ **D66 Hemophilia A(Factor VIII deficiency)**
☐ **D67 Hemophilia B (Factor IX deficiency)**
☐ **D68.1Hemophilia C(Factor XI deficiency)**
☐ **D68.2 Hereditary Deficiency of other clotting factors**
☐ **D68.01 WD Type 1**
☐ **D68.02 VWD Type 2**
☐ **D68.03 VWD Type 3**
☐ **D69.1 Qualitative platelet defects**
☐ **D68.311 Acquired hemophilia**
☐ **D68.9 Coagulation defect, unspecified**
Other:_____

PATIENT EVALUATION

Severity: ____**%**baseline ☐ Severe ☐ Moderate ☐ Mild Other:_____
Inhibitor: ☐ None ☐ Hx but resolved Current BU:_____ Historic High:_____
Patient Weight:_____ kg/lb _____ **Height:** _____ cm/in ____
Allergies: _____
Access: ☐ Butterfly ☐ Port ☐ PICC ☐ PIV ☐ N/A Other_____
Nursing: Pharmacy coordinate home health nursing visits as necessary ☐ Yes ☐No
Other significant (atypical kinetics, bleed/asap, procedure/date, target joints):____
_____

MEDICATION	DOSE	UNIT	ROUTE	DIRECTIONS/FREQUENCY	QUANTITY	REFILLS

FACTOR (Circle)

_____ _____ units/mg +/-10%IV _____ _____doses _____ref
_____ _____ units/mg +/-10%IV _____ _____doses _____ref
_____ _____ units/mg +/-10%IV _____ _____doses _____ref

FACTOR MIMETIC (if Hemlibra, OK nearest combination of 12 and 30mg OR 60, 105, 150, and 300mg, waste the rest)

_____ _____ mg subcutaneously _____ _____ doses _____ ref
_____ _____ mg subcutaneously _____ _____ doses _____ ref
_____ _____ mg subcutaneously _____ doses _____ ref

REBALANCING AGENTS (Hympavzi 150mg single-use pen; Alhemo 60, 150, 300mg multi-use pens nearest combo, waste rest) (Circle)

_____ _____ mg subcutaneously _____ _____ doses/pens ____ref
_____ _____ mg subcutaneously _____ doses/pens ____ref
_____ _____ mg subcutaneously _____ doses/pens ____ref

OTHER (Amicar please prescribe multiples of 8 oz bottles for 25% oral soln; or tabs multiples of #30 for Amicar or Lysteda)

Drug name/descript.	Dose	DoseUnit	Route	Directions/Frequency	Quantity	QtyUnit	Refills
_____	_____	_____	____	_____	_____	_____	_____ref
_____	_____	_____	____	_____	_____	_____	_____ref
_____	_____	_____	____	_____	_____	_____	_____ref
_____	_____	_____	____	_____	_____	_____	_____ref

Sodium chloride 0.9% 10ml pref syr Flush with _____ ml _____ _____ syringes _____ref
Heparin 5ml pref syr ☐10unit/ml ☐ 100unit/ml Flush with ___ ml _____ syr _____ ref
Emla 30gram cream Apply ~5 gm topically_____ _____tube(s) _____ ref
FOR ALL MEDICATIONS:OK to dispense all necessary supplies.

Prescriber Signature:_____ **Date:**_____
Generic substitution allowed unless hand write Brand Medically Necessary