Hemophilia

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Please complete each section of the referral form below and fax to OptiMed along with a copy (front and back) of all the patient's pharmacy and medical insurance cards, the patient's demographic face sheet, and any relevant clinical notes/documents.

Prescriber Information

Prescriber: ______________________ **NPI:** ______________________

Phone: ______________ **Fax:** ______________ **Office Contact:** ______________

Address: ____

Patient Information

Name: ______________________ **DOB:** ______________________ ☐M ☐F

Address: ____

Phone: ______________ **2nd Phone:** ______________ **SSN:** ______________

Primary Language: ______________ **Functional Limitations:** ______________

Clinical Information

Primary Diagnosis:

286 Hemophilia A (Factor VIII Deficiency).
☐ D66 Hereditary Factor VIII.

286.1 Congenital Factor IX Disorder (Hemophilia B).
☐ D67 Hereditary Factor IX Deficiency.

286.2 Congenital Factor XI Disorder (Hemophilia C).
☐ D68.1 Hereditary Factor XI Disorder.

286.4 Von Willebrand Disease.
☐ D68.1 Hereditary Factor XI Disorder.

286.9 Coagulation Defect NEC/NO.
☐ D68.8 Other Specified Coagulation Defects

Other ICD-10: ☐ ____

FVIII/FIX assay: __________U/ml **FXIII/FIX activity:** __________% **Inhibitor Titer:** __________BU/ml **Date:** __________

Patient's first dose? ☐Yes ☐No, Start date: __________ Date of last dose: __________ **Prior infusion reactions:** __________

Weight: ________ ☐lb ☐kg **Height:** ________ ☐in **Administration:** ☐PICC ☐Port ☐IV Catheter ☐Central Line ☐Butterfly ☐Other ______

Allergies: ____ **Latex allergy?** ☐Yes ☐No

Prior treatments & reason for discontinuation: ____

____

Medications

☐ Advate	☐ BeneFIX	☐ Idelvion	☐ NovoSeven RT	☐ Stimate
☐ Adynovate	☐ Corifact	☐ IXINITY	☐ Nuwiq	☐ Tratten
☐ Afstyla	☐ Eloctate	☐ Koate DVI	☐ Obizur	☐ Wilate
☐ Alphanate	☐ Feiba	☐ Kogenate FS	☐ Profilnine	☐ Xyntha
☐ AlphaNine	☐ Helixate	☐ Monoclate-P	☐ Rebinyn	☐ Other
☐ Alprolix	☐ Hemofil	☐ Mononine	☐ Recombinate	________
☐ Bebulin	☐ Humate-P	☐ Novoeight	☐ Rixubis	

☐ 0.9% sodium chloride 5-10mL pre/post infusion and PRN
☐ Heparin 10 Units/mL 5mL post infusion and PRN
☐ Heparin 100 Units/mL 5mL post infusion and PRN
☐ Standard supplies for administration as requested
☐ Sharps container
☐ Other ______________________

Prescription Information

Prophylactic Dosing: Dose: ______________ Frequency: ______________ Refills: __________ Goal: ______________

☐ Dispense 30-day supply based on frequency ☐ Dispense ________ doses for a 30-day supply

Episodic Dosing: Bleeding Dose: ____

☐ Dispense 30-day supply based on frequency ☐ Dispense ________ doses for a 30-day supply

Prescriber Signature

My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize OptiMed and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide administrative nursing services and supplies in conjunction with the therapy prescribed above.

Signature: ______________________________ **Date:** ______________________

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