



Hemophilia & Bleeding Disorders Intake Form

Northborough, MA: Toll free (855) 880-1091 Toll free fax (844) 265-0265

www.AllCarePlusPharmacy.com

DATE: _____ THERAPY START DATE: _____ DELIVERY : PATIENT OFFICE OTHER: _____

PATIENT INFO			PRESCRIBER INFO	
Patient Name			Prescriber Name	
Address			Preparer Name/Office Contact	
City, State, Zip			Address	
Phone			City, State, Zip	
Social Security	Hgt.	Wt.	Phone	Fax
Date of Birth			DEA/NPI #	
<input type="checkbox"/> Male <input type="checkbox"/> Female				

INSURANCE: PLEASE FAX COPY OF PRESCRIPTION CARD & MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis (ICD-10 Code):

- D66 Hereditary factor VIII deficiency D68.311 Acquired hemophilia
 D67 Hereditary factor IX deficiency D66 Hereditary factor VIII deficiency
 D68.0 Von Willebrand's disease D68.318 Other hemorrhagic disorder due to intrinsic circulating anticoagulants, antibodies, or inhibitors
 Other ICD-10 Code: _____

Patient Clinical Information:

Factor Level: _____
 Severity: Severe (<1%) Moderate (1-5%) Mild(>5%)
 Allergies: _____
 Weight: _____ Height: _____
 Access: Peripheral Butterfly
 Phylaxis: PICC Implant Port Broviac®/ Hickman®
 Notes: _____

Nursing:

Specialty Pharmacy to coordinate injection training/home health nurse visit as necessary? Yes No
 Site of Care: MD office Infusion Clinic Outpatient Health Home Health

PRESCRIPTION INFORMATION

PRODUCT NAME	DOSE/UNITS/Kg	ROUTE	FREQUENCY	QUANTITY	REFILLS
Factor VIII (Recombinant) <input type="checkbox"/> Advate® <input type="checkbox"/> Helixate® FS <input type="checkbox"/> NovoEight® <input type="checkbox"/> Xyntha® <input type="checkbox"/> Adynovate® <input type="checkbox"/> Kogenate® FS <input type="checkbox"/> Nuwiq® <input type="checkbox"/> Eloctate® <input type="checkbox"/> Kovaltry® <input type="checkbox"/> Recombinate®					
Factor IX <input type="checkbox"/> AlphaNine® SDVF <input type="checkbox"/> Benefix® <input type="checkbox"/> Mononine® <input type="checkbox"/> Alprolix® <input type="checkbox"/> IDELVION® <input type="checkbox"/> Proflinine® SD <input type="checkbox"/> Bebulin® VH <input type="checkbox"/> Ixinity® <input type="checkbox"/> Rixubis®					
Factor XIII <input type="checkbox"/> Corifact® <input type="checkbox"/> Tretten® <input type="checkbox"/> Amicar® Tablet <input type="checkbox"/> Amicar® Syrup <input type="checkbox"/> Lysteda™ <input type="checkbox"/> Stimate®					
Von Willebrand Products <input type="checkbox"/> Alphanate® SDHT <input type="checkbox"/> Humate P® <input type="checkbox"/> Koate® DVI <input type="checkbox"/> Wilate®					
Inhibitor Therapies <input type="checkbox"/> Feiba® VH <input type="checkbox"/> NovoSeven® <input type="checkbox"/> Other: _____ <input type="checkbox"/> Ancillary Supplies					

Physician Signature: _____ Date: _____

I authorize AllCare Plus Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network. In no event should the material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee. This is a patient enrollment form for the above mentioned therapies. Patients have the right to use the Pharmacy of their choice, if AllCare Plus Pharmacy is the Pharmacy of choice, please follow up with a call in, electronic, faxed or mailed prescription to AllCare Plus Pharmacy, 50 Bearfoot Road, Northborough, MA 01532. (Phone) 1 855 880 1091 (Fax) 1 844 265 0265