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

Patient Name

Address

City, State, Zip

Phone

Social Security Hgt. Wt.

Date of Birth ☐ Male ☐ Female

PRESCRIBER INFO

Prescriber Name

Preparer Name/Office Contact

Address

City, State, Zip

Phone Fax

DEA/NPI #

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

CLINICAL INFORMATION

Diagnosis (ICD-10 Code):

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

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

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: _____

PRESCRIPTION INFORMATION

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