

# BLEEDING DISORDERS REFERRAL FORM



210 Rock Road | Glen Rock, NJ 07452  
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Toll Free: 866-888-3200

Today's Date

CURRENT PATIENT  
 NEW PATIENT

FEB 2018

Patient Name \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_  
Address \_\_\_\_\_ Apt # \_\_\_\_\_  Male  Female  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Daytime Tel \_\_\_\_\_ Cell \_\_\_\_\_  
Email \_\_\_\_\_  
Ship to Patient at  Home  Work OR Patient will pick up at  Physician Office  Pharmacy Date Needed \_\_\_\_\_

D66 Hereditary Factor VIII Deficiency  D67 Hereditary Factor IX Deficiency  
 D68.1 Hereditary Factor XI Deficiency  D68.2 Hereditary Deficiency of other Clotting Factors  
 D68.0 von Willebrand Disease  D68.4 Acquired Coagulation Factor Deficiency  
 D68.9 Coagulation Defect, Unspecified  Other ICD-10 \_\_\_\_\_

Description \_\_\_\_\_  
Baseline factor percent \_\_\_\_\_ Target joint(s)  No  Yes \_\_\_\_\_ Inhibitor:  No  History  Current \_\_\_\_\_ BU/ml  
Inhibitor protocol \_\_\_\_\_

DNR/Advance directive status:  Received  N/A Hep B, Hep C, HIV or TB positive? (circle) Date chest x-ray \_\_\_\_\_  
Allergies \_\_\_\_\_ Comorbidities \_\_\_\_\_

Current Medications (if necessary, please fax a complete list) \_\_\_\_\_  
Vascular access:  Peripheral  Port  Other Weight \_\_\_\_\_  kg  lbs Height \_\_\_\_\_  cm  in

Insured's Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
Eligible for Medicare  Yes  No If yes, Medicare# \_\_\_\_\_ Prescription Card  Yes  No If Yes, Carrier \_\_\_\_\_  
Tel \_\_\_\_\_ Fax \_\_\_\_\_ Policy/Group# \_\_\_\_\_  
Bin# \_\_\_\_\_ Pcn# \_\_\_\_\_ RXID# \_\_\_\_\_ RX Group# \_\_\_\_\_

Prescriber's Name \_\_\_\_\_ Office Contact \_\_\_\_\_  
Street Address \_\_\_\_\_ Suite# \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Tel \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_  
License# \_\_\_\_\_ NPI# \_\_\_\_\_ UPIN# \_\_\_\_\_ DEA# \_\_\_\_\_

## PRESCRIPTION PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

EpiPen Adult (0.3 mg) as directed for reactions, qty:1  EpiPen Jr (0.15 mg) as directed for reactions, qty:1  
**Factor VIII recombinant:**  Advate  Helixate FS  Kogenate FS  Recombinate  Xyntha  Other: \_\_\_\_\_  
Plasma derived:  Hemofil M  Monoclate-P  Other \_\_\_\_\_  
Approximate units and directions: \_\_\_\_\_ Dispense qty: \_\_\_\_\_ Refills: \_\_\_\_\_  
**Factor VIII and von Willebrand plasma derived:**  Alphanate  Humate-P  Koate-DVI  Wilate  Other: \_\_\_\_\_  
Approximate units  VWF  Factor VIII and directions: \_\_\_\_\_ Dispense qty: \_\_\_\_\_ Refills: \_\_\_\_\_  
**Factor IX recombinant:**  BeneFix  Alprolix  Rixubis  Other \_\_\_\_\_  
Plasma derived:  AlphaNine SD  Mononine  Other: \_\_\_\_\_  
Approximate units and directions: \_\_\_\_\_ Dispense qty: \_\_\_\_\_ Refills: \_\_\_\_\_  
**Factor VII recombinant:**  NovoSeven RT  Other \_\_\_\_\_  
Dose (mg) and direction: \_\_\_\_\_ Dispense qty: \_\_\_\_\_ Refills: \_\_\_\_\_  
**Activated Prothrombin Complex Concentrates plasma derived:**  Feiba VH  Other \_\_\_\_\_  
Approximate units and directions: \_\_\_\_\_ Dispense qty: \_\_\_\_\_ Refills: \_\_\_\_\_  
**Prothrombin Complex Concentrates plasma derived:**  Bebulin VH  Profilnine SD  Other \_\_\_\_\_  
Approximate units and directions: \_\_\_\_\_ Dispense qty: \_\_\_\_\_ Refills: \_\_\_\_\_  
**Stimate** 1 spray in  one nostril  each nostril \_\_\_\_\_ Dispense qty: \_\_\_\_\_ Refills: \_\_\_\_\_  
**Amicar**  syrup  500/1000 mg tab Dose and directions: \_\_\_\_\_ Dispense qty: \_\_\_\_\_ Refills: \_\_\_\_\_  
**Other** (continuous infusion, Rituxan, vancomycin, etc): \_\_\_\_\_

**Line care:**  Sodium chloride 0.9% 5-10ml  3-5 ml Heparin ( 10 units/ml  100 units/ml)  Other: \_\_\_\_\_  
 Apply 30-60 minutes prior to access ( Emla 30 gram  LMX 30 gram)  Other: \_\_\_\_\_  
**Nursing orders:**  Skilled nurse to infuse/teach mixing infusion, self-monitoring, other aspects of care \_\_\_\_\_  
Lab orders: \_\_\_\_\_  
Supplies:  All infusion and prevention supplies as needed and/or: \_\_\_\_\_

By signing this form and utilizing our services, you are authorizing Glen Rock Medical Pharmacy and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.  
**Prescriber's Signature** (signature required. NO STAMPS) \_\_\_\_\_ **Date** \_\_\_\_\_

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