Hemophilia Referral Form

Please Fax copy(s) of patient's insurance card(s) with referral.

6820 Charlotte Pike | Nashville, TN 37209 | Phone: 800.800.6606 | Fax: 800.330.0756

Upon Receipt of this form, pharmacy will fill covered prescriptions and send to patients' address as directed.

Patient Name:			Phone #:
Address:			
DOB:	Sex:	Allergies:	
SSN#:		Patient Representative:	Marital Status:

Primary Ins. Co:		Ph.#:
Name of Insured:		Relationship:
Insured SS#:	DOB:	Employer:
Group #:	Policy #:	Member #:
Pharmacy Benefits Manager:		Ph.#:

Secondary Ins. Co:		Ph.#:
Name of Insured:		Relationship:
Insured SS#:	DOB:	Employer:
Group #:	Policy #:	Member #:
Pharmacy Benefits Manager:		Ph.#:

Hemophilia Type: ☐ A ☐ B ☐ vWD ☐ Other Severity: ☐ Mild ☐ Moderate ☐ Severe	Height:	Weight:
IV Access: ☐ PIV/Buttterfly ☐ PICC ☐ Port a Cath ☐ Central Line	Inhibitors: ☐ No ☐ Yes	
Target Joint(s): ☐ No ☐ Yes Location:		
☐ Skilled nursing visits to be provided for infusions ☐ Skilled nursing visits to be provided for teaching		
Additional Requirements:		

Clotting Factor Orders			
Brand Name:	Dose:	Qty:	Frequency:
Brand Name:	Dose:	Qty:	Frequency:

Dosage: Mild units/kg _____	**Severe units/kg** _____
Prophylaxis # Doses _____ /WK Dispense for _____ MO(S)	
Episodic Dispense _____ Doses for Mild / _____ Doses for Severe	

Ancillary Meds/Supplies	
☐ Amicar _____MG Directions:	☐ Heparin _____u/ml _____cc flush
☐ Stimate 1.5mg/ml Spray in ☐ Each ☐ Both nostril(s) as directed	☐ Saline Flush _____ cc
☐ Emla Apply topically as needed to IV site one to one-half hour prior to insertion prn. _____	
☐ LMX Apply topically as needed to IV site one to one-half hour prior to insertion prn. _____	
☐ CryoCuff to be applied to affected site/joint prn _____. Site _____	
☐ Other:	

Prescriber:	Office Contact:	
Address:		
Phone #:	Fax #:	
License #:	NPI #:	DEA #:

Refills _____ Refill x _____ YR/MO

Dispense As Written ☐

_____ _____

Signature Date