



# Hemophilia Referral Form

Phone: (866) 202-9552

Fax: (866) 794-4844



Please fax front and back of patients insurance card

## PATIENT INFORMATION

Patient Name:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Drug Allergies:	<input type="checkbox"/> NKDA
Date of Birth:	SSN#	Weight _____	<input type="checkbox"/> kg	<input type="checkbox"/> lb Date:
Address:	City:	State:	Zip:	
<input type="checkbox"/> Ph # (Home)	<input type="checkbox"/> (Work)	<input type="checkbox"/> Email address:		

## INSURANCE INFORMATION

Primary Insurance:	Policyholder:
Group #	Policy #
Secondary Insurance	Policy #
	Phone #

## DIAGNOSIS/MEDICAL INFORMATION (Please specify primary and secondary diagnoses)

Primary ICD-9	Secondary ICD-9
Is patient new to therapy? <input type="checkbox"/> yes <input type="checkbox"/> no Date of diagnosis:	

## MEDICAL INFORMATION

Hemophilia Type: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> vWD <input type="checkbox"/> Other	Height:	Weight:
Severity: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe		
IV Access: <input type="checkbox"/> PIV/Butterfly <input type="checkbox"/> PICC <input type="checkbox"/> Port a Cath <input type="checkbox"/> Central Line	Inhibitors: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Target Joints(s): <input type="checkbox"/> No <input type="checkbox"/> Yes Location:		
<input type="checkbox"/> Skilled nursing visits to be provided for infusions	<input type="checkbox"/> 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 _____ Doses for Mild / _____		Does for Severe	

## Ancillary Meds/Supplies

<input type="checkbox"/> Amicar _____ MG Directions:	<input type="checkbox"/> Heparin _____/ml _____ cc flush
<input type="checkbox"/> Stimate 1.5mg/ml Spray in <input type="checkbox"/> Each <input type="checkbox"/> Both nostril(s) as directed	<input type="checkbox"/> Saline Flush _____ cc
<input type="checkbox"/> Emla Apply topically as needed to IV site one to one-half hour prior to insertion prn. _____	
<input type="checkbox"/> LMX Apply topically as needed to IV site one to one-half hour prior to insertion prn. _____	
<input type="checkbox"/> Other:	

## PHYSICIAN CONTACT INFORMATION & AUTHORIZATION

Physician Name:	Office Contact:	Institution:
Phone:	Fax:	Specialty:
Address:	City/State/Zip:	
License #	DEA #	UPIN#
		NPI#
# Refills _____	Refill x _____	YR/MO

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

(required to process prescription - stamped signatures are not permissible)

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