



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 #:
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Address:

DOB:	Sex:	Allergies:
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SSN#:	Patient Representative:	Marital Status:
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Primary Ins. Co:	Ph.#:
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Name of Insured:	Relationship:
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Insured SS#:	DOB:	Employer:
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Group #:	Policy #:	Member #:
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Pharmacy Benefits Manager:	Ph.#:
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Secondary Ins. Co:	Ph.#:
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Name of Insured:	Relationship:
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Insured SS#:	DOB:	Employer:
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Group #:	Policy #:	Member #:
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Pharmacy Benefits Manager:	Ph.#:
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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/Buttterfly <input type="checkbox"/> PICC <input type="checkbox"/> Port a Cath <input type="checkbox"/> Central Line	Inhibitors: <input type="checkbox"/> No <input type="checkbox"/> Yes
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Target Joint(s): <input type="checkbox"/> No <input type="checkbox"/> Yes	Location:
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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:
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Brand Name:	Dose:	Qty:	Frequency:
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Dosage: Mild units/kg _____	Severe units/kg _____
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Prophylaxis # Doses _____ /WK Dispense for _____ MO(S)

Episodic Dispense _____ Doses for Mild / _____ Doses for Severe

Ancillary Meds/Supplies

<input type="checkbox"/> Amicar _____ MG Directions:	<input type="checkbox"/> Heparin _____ u/ml _____ cc flush
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<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
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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:
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Address:

Phone #:	Fax #:
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License #:	NPI #:	DEA #:
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Refills _____ Refill x _____ YR/MO

Dispense As Written

Signature _____

Date _____