ALLIED PHARMACY

Hemophilia & Bleeding Disorder

Ph: 832-365-3420 Fax: 855-595-2955

Injection Training: ☐ MD Office ☐ Pharmacy to Arrange

Ship To : ☐ Patient Home ☐ MD Office

MAIN POINT OF CONTACT

Name:_____

Phone:_____

PATIENT INFORMATION (Use this area or attach patient demographics)

Name:_____ Phone:_____ Phone 2:_____

Home Address:_____ City:_____ State:_____ Zip Code:_____

DOB:_____ SSN:_____ Sex: ☐ Male ☐ Female Height:_____ Weight:_____lbs.

Emergency Contact:_____ Phone:_____

INSURANCE INFORMATION (Use this area or attach copy of insurance card(s))

Primary Insurance:_____ Secondary Insurance:_____

ID#:_____ RxBin:_____ ID#:_____ RxBin:_____

RxGroup:_____ Pcn:_____ RxGroup:_____ Pcn:_____

DIAGNOSIS (ICD-10) and Allergy:

☐ D66 Hereditary Factor VIII Deficiency
☐ D67 Hereditary Factor IX Deficiency
☐ D68.0 Von Willebrand's Disease
☐ D68.311 Acquired Hemophilia
☐ D68.318 Other Hemorrhagic Disorder due to Intrinsic Circulating Anticoagulants, Antibodies, or Inhibitors
☐ Other:_____ Description:_____

Allergies:

Medication	Strength	Directions	Qty.	Refills
☐ Advate ☐ Adynovate ☐ Afstyla ☐ Alphanate ☐ Elocatte ☐ Helixate ☐ Hemofil-M ☐ Koate-DVI ☐ Kogenate FS ☐ Kovaltry ☐ Monoclate-P ☐ Novoeight ☐ Nuwiq ☐ Recombinate ☐ Xyntha ☐ AlphaNine ☐ Alprolix ☐ Bebulin ☐ BeneFIX ☐ Idelvion ☐ IXINITY ☐ Mononine ☐ Profilnine ☐ Rixubis	_____IU/kg	☐ Prophylaxis:_____ ☐ Immune Tolerance:_____ ☐ Breakthrough Bleed: Infuse _____units (+/- 10%) slow IV push every _____ ☐ hours ☐ days for a total of _____doses as needed for bleeding episodes. Contact your physician's office if bleeding does not resolve. Minor: ☐ _____IU q_____ hr PRN ☐ Other:_____ Major: ☐ _____IU q_____hr PRN ☐ Other:_____	☐ 1 Month ☐ 3 Months ☐ _____	☐ 1 Year ☐ _____
☐ Feiba NF ☐ Humate-P ☐ Vonvendi ☐ Wilate ☐ Corifact ☐ Tretten ☐ Ceprotin ☐ Thrombate III				
☐ NovoSeven RT	_____mg	Infuse _____mg slow IV push every _____hours and/or_____		
☐ Amicar Tablet ☐ Amicar Syrup	_____mg/kg			
☐ Stimate	☐ 150 mcg ☐ 300 mcg	☐ Weight < 50kg: Single spray in one nostril ☐ Weight > 50kg: Single spray in BOTH nostrils		
☐ Normal Saline		_____mL every_____ Access Device: ☐ Port ☐ PICC ☐ PIV ☐ Butterfly ☐ Other_____		
☐ Heparin	☐ 10 IU/mL ☐ 100 IU/mL	_____mL every_____		
☐ Epi-Pen ☐ Epi-Pen Jr.		☐ PRN Anaphylaxis ☐ Other:_____	☐ 1 Pen ☐ 2 Pens ☐ ____ Pens	

Prescriber Name:_____ NPI#:_____

Address:_____ City:_____ State:____ Zip Code:_____

Phone:_____ Fax:_____

***Prescriber Signature:_____Date:_____**

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Please fax completed form to 1 855-595-2955