

# Bleeding disorders referral form

Infusion Pharmacy Phone: 1-855-855-8754 Fax: 1-800-311-0185

✂ Please detach before submitting to a pharmacy—tear here.

Representative: \_\_\_\_\_ Phone: \_\_\_\_\_

## Patient information see attached

Patient name: \_\_\_\_\_ Gender:  M  F DOB: \_\_\_\_\_ Last 4 of SSN: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Insurance:  Front and back of insurance cards to follow

Primary Insurance: \_\_\_\_\_ Phone: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Phone: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group: \_\_\_\_\_

## Physician orders:

Current patient need:  Procedure scheduled for \_\_\_\_\_  STAT/URGENT bleed  Ongoing care, not an urgent request

Factor brand name: \_\_\_\_\_

Prophylactic dose: \_\_\_\_\_ (+/- \_\_\_\_\_ %) Freq: \_\_\_\_\_ Qty: \_\_\_\_\_ Refills: \_\_\_\_\_

Bleed dose: \_\_\_\_\_ (+/- \_\_\_\_\_ %) Freq: \_\_\_\_\_ Qty: \_\_\_\_\_ Refills: \_\_\_\_\_

Bleed dose: \_\_\_\_\_ (+/- \_\_\_\_\_ %) Freq: \_\_\_\_\_ Qty: \_\_\_\_\_ Refills: \_\_\_\_\_

Bleed dose: \_\_\_\_\_ (+/- \_\_\_\_\_ %) Freq: \_\_\_\_\_ Qty: \_\_\_\_\_ Refills: \_\_\_\_\_

Other Drug: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Frequency: \_\_\_\_\_ Qty: \_\_\_\_\_ Refills: \_\_\_\_\_

Other Drug: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Frequency: \_\_\_\_\_ Qty: \_\_\_\_\_ Refills: \_\_\_\_\_

IV access:  PIV/Butterfly needle  CVAD  Implantable port

Flush PIV with Sodium Chloride 0.9%: 5ml pre- and post- infusion. If Port access: Sodium Chloride 0.9%, 10ml pre- and post-infusion followed by Heparin 100 units/ml, 5ml as final lock for patency (for other orders, contact pharmacy).

Skilled nursing to administer/teach preparation, infusion, self-monitoring of prescribed medication and to establish/maintain IV access as required.

Pharmacy to dispense needles, syringes, flushes, HME/DME in quantity sufficient to complete therapy as prescribed.

Anaphylaxis management x1 year (Select check box to order.)

### For Anaphylaxis

• Stop infusion and remove infusion set needle from body to prevent further administration of causative drug

• **Administer contents of EPINEPHrine autoinjector (pen) as an IM injection into the lateral thigh**

• Repeat EPINEPHrine in 5 to 15 minutes if symptoms persist

• Administer CPR if needed until EMS arrive

• Notify prescribing physician after EMS care is received and condition is stable

Pharmacy to dispense weight (Wt) appropriate EPINEPHrine pen x 2, 0.3mg/0.3ml if Wt >66lbs (>30kg), 0.15mg/0.15ml if Wt 33 to 66lbs (15 to 30kg), 0.1mg/0.1ml if Wt <33lbs (<15kg).

\*Call 911\*

## Clinical information:

Primary diagnosis: Please select a diagnosis and severity level, if appropriate

**D66:** Hereditary factor VIII  Mild  Moderate  Severe

**D67:** Hereditary factor IX  Mild  Moderate  Severe

**D68:** Hereditary deficiency of other clotting factors

**D68.1:** Von Willebrand  Type 1  Type 2  Type 3

**D68.2:** Hereditary factor XI deficiency  Mild  Moderate  Severe

**D68.311:** Acquired hemophilia

Other: \_\_\_\_\_

Patient has inhibitor?  Yes  No If positive,  >5 BU or  ≤5 BU or  unknown

Target Joints: \_\_\_\_\_

## Physician information

Name: \_\_\_\_\_ Practice: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ NPI: \_\_\_\_\_ Contact: \_\_\_\_\_

By signing, I certify/recertify that the above therapy, products and services are medically necessary and that this patient is under my care. I have received authorization to release the above referenced information and medical and/or patient information relating to this therapy. Pharmacy has my permission to contact the insurance company on my behalf to obtain authorization for patient.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please fax:  Completed form  Demographic sheet/insurance information  Clinical notes and labs

**This form is not a valid prescription in New York.**