AcariaHealth™
Specialty Pharmacy

Phone: 866.506.2626 • Fax: 800.696.0607

Date Shipment Needed: _____ Ship To: ☐ Patient ☐ Prescriber

HEMOPHILIA AND CLOTTING DISORDER REFERRAL FORM

PATIENT INFORMATION

Patient Name:		DOB:	Sex: ☐ M ☐ F ☐ Other:	Weight:	☐ lbs. ☐ kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	☐ **Additional Information Attached**		

PRESCRIBER INFORMATION

Prescriber:		NPI:	DEA:	State Lic:
Supervising Physician:		Practice Name:		
Address:		City:	State:	Zip:
Phone:	Fax:	Key Office Contact:		Phone:

DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT

Primary Diagnosis: (ICD-10 Code & Description) ☐ D66 Hereditary factor VIII deficiency ☐ D67 Hereditary factor IX deficiency ☐ D68.0 Von Willebrand's disease
☐ D68.311 Acquired Hemophilia ☐ D68.8 Other specified coagulation defects ☐ D68.9 Coagulation defect, unspecified ☐ D68.2 Hereditary deficiency of other clotting factors
☐ Other Code: _____ Description: _____

- Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile): _____

INSURANCE INFORMATION

☐ **Please attach front and back of patient's insurance card (medical and prescription)**

COPAY CARD ENROLLMENT

☐ **Please check if enrolling in copay card** | **Copay ID:**

NURSING

☐ Skilled Nursing Needed: ☐ No ☐ Yes (NOTE: not available for PRN or pre-op dosing) As needed for IV access, administration, and proper clinical monitoring.
If yes, specify services needed: ☐ Teach & Train (up to 3 visits) ☐ Post-Op (Must include date of procedure: _____)
Site of Care: ☐ MD office ☐ Infusion Clinic ☐ Outpatient Health ☐ Home Health

PRESCRIPTION INFORMATION

FACTOR REPLACEMENT			PROPHYLAXIS	BREAKTHROUGH BLEEDS	BREAKTHROUGH BLEEDS	REFILLS
☐ Advate ☐ Adynovate ☐ Afstyla ☐ **Alphanate*** ☐ Alphanine ☐ Alprolix ☐ Altuviiio ☐ Benefix	☐ Eloctate ☐ Hemofil-M ☐ **Humate-P*** ☐ Idelvion ☐ Ixinity ☐ Jivi ☐ Kovaltry ☐ Novoeight	☐ Nuwiq ☐ Recombinate ☐ Rixubis ☐ Vonvendi ☐ **Wilate*** ☐ Xyntha ☐ Other: _____	**Dose:** _____ units **Assay Variance:** +/- 10% or ☐ Other: _____ **Route:** IV **Frequency:** _____ **Dose Quantity:** _____ * For these products, indicate if doses are expressed as Factor VIII or VWF:RCoF units	**Bleed Type:** ☐ Major ☐ Minor ☐ Other: _____ **Dose:** _____ units **Assay Variance:** +/- 10% or ☐ Other: _____ **Route:** IV **Frequency:** _____ prn **Dose Quantity:** _____	**Bleed Type:** ☐ Major ☐ Minor ☐ Other: _____ **Dose:** _____ units **Assay Variance:** +/- 10% or ☐ Other: _____ **Route:** IV **Frequency:** _____ prn **Dose Quantity:** _____	11 or _____

Alhemo *(Hemophilia A&B with inhibitors)* — ☐ Loading dose: Inject 1 mg/kg (Day 1) SQ x 1; ☐ Maintenace dose: Inject 0.2 mg/kg SQ daily x 4 weeks; *(measure Concizimab-mtci plasma conc)*
☐ Individualized Maintenance Dose: Inject _____ mg/kg SQ daily; Refills: _____ ;
Hympavzi *(Hemophilia A&B without inhibitors)* — ☐ Loading dose: Inject 300 mg SQ x 1; ☐ Maintenance dose: Inject 150 mg SQ weekly; Refills: _____

HEMLIBRA	LOADING DOSE	MAINTENANCE DOSE	BREAKTHROUGH BLEEDS	REFILLS
☐ Hemlibra 30 mg/mL (will require separate injection) ☐ Hemlibra 60 mg/0.4 mL ☐ Hemlibra 105 mg/0.7 mL ☐ Hemlibra 150 mg/mL May use any combination of available strengths to dispense calculated dose, unless otherwise requested	☐ No Loading Dose Needed ☐ 3 mg/kg SQ once weekly for 4 weeks **Calculated Dose:** _____ mg **Dose Quantity:** __4__ ; **Refills:** __0__	☐ 1.5 mg/kg SQ every week ☐ 3.0 mg/kg SQ every 2 weeks ☐ 6.0 mg/kg SQ every 4 weeks **Calculated Dose:** _____ mg **Dose Quantity:** _____ ; **Refills:** _____	**Please select a Factor VIII product in the section above for treatment of breakthrough bleeds while on Hemlibra**	11 or _____

ANCILLARY MEDICATIONS / SUPPLIES

PRODUCT	DIRECTIONS	QUANTITY	REFILLS
☐ Sodium chloride 0.9% flush syringe (10 mL)	Access Device: ☐ Port ☐ PICC ☐ PIV ☐ Butterfly Flush with _____ mL every _____	☐ 1 month ☐ 3 months ☐ Other: _____	11 or _____
☐ Heparin 10 units/mL flush syringe (5 mL) ☐ Heparin 100 units/mL flush syringe (5 mL)	Access Device: ☐ Port ☐ PICC ☐ PIV ☐ Butterfly Flush with _____ mL every _____	☐ 1 month ☐ 3 months ☐ Other: _____	11 or _____
☐ Needles and Syringes	Use as directed for administration of infused/injected medication	☐ 1 month ☐ 3 months ☐ Other: _____	11 or _____
Epinephrine is Required for Nursing ☐ Epinephrine 0.3 mg auto-injector (Adult: > 30 kg) ☐ Epinephrine 0.15 mg auto-injector (15-30 kg)	Inject 1 pen IM PRN severe allergic reaction – Call 911 May repeat in 5-15 minutes as needed	☐ 1 Box (2 Pens) ☐ Other: _____	11 or _____
☐ Lidocaine/Prilocaine 2.5% / 2.5% cream	Apply to injection site as needed **Day Supply:** _____	☐ 1 Tube (30 grams) ☐ Other: _____	11 or _____
☐ **Other Product:** _____	**Directions:** _____ (Include dose, route and frequency)	**Quantity:** _____	11 or _____

Prescriber's Signature: _____ **Date:** _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.