



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 #:	
Address:			
DOB:	Sex:	Allergies:	
SSN#:	Patient Representative:		Marital Status:
Primary Ins. Co:		Ph.#:	
Name of Insured:		Relationship:	
Insured SS#:	DOB:	Employer:	
Group #:	Policy #:	Member #:	
Pharmacy Benefits Manager:		Ph.#:	
Secondary Ins. Co:		Ph.#:	
Name of Insured:		Relationship:	
Insured SS#:	DOB:	Employer:	
Group #:	Policy #:	Member #:	
Pharmacy Benefits Manager:		Ph.#:	
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	
Target Joint(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 Dispense _____ Doses for Mild / _____ Doses for Severe			
Ancillary Meds/Supplies			
<input type="checkbox"/> Amicar _____ MG Directions:		<input type="checkbox"/> Heparin _____ u/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"/> CryoCuff to be applied to affected site/joint prn _____. Site _____			
<input type="checkbox"/> Other:			
Prescriber:		Office Contact:	
Address:			
Phone #:		Fax #:	
License #:		NPI #:	DEA #:

Dispense As Written

Refills _____ Refill x _____ YR/MO

Signature _____

Date _____