# 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:

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**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**<br><br>***Call 911*** | • Stop infusion and remove infusion set needle from body to prevent further administration of causative drug<br>• **Administer contents of EPINEPHrine autoinjector (pen) as an IM injection into the lateral thigh**<br>• Repeat EPINEPHrine in 5 to 15 minutes if symptoms persist<br>• Administer CPR if needed until EMS arrive<br>• Notify prescribing physician after EMS care is received and condition is stable<br>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). |

## 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.**