

HEMATOLOGY®

Please Fax Completed Form To: 800-783-9146

Name:DOB:Prescriber Name:	PATIENT INFORMATION (Compl	lete or Eav Existing Chart		PRESCRIBER INFORMATION			
Address:							
Cry, State, Zip:			DOB				
City, State, Zip							
Email	City, State, Zip:						
Phone	Phone: Alt. Phone:						
Office Contact:	Email:	SS#:		City, State, Zip:			
Primary insurance:	Gender: □M □F Weight: _	(lbs)	Ht:	Phone: Fax:			
Primary Insurance:	Allergies:			Office Contact: Phone:			
Selection Pince	INSURANCE INFORMATION – O	R – Send a copy of the pa	tient's prescription/insurance ca	rds (front & back)			
Fig.	Primary Insurance:			RX Card (PBM):			
Group #:				BIN: PCN:			
Phone: CUNICAL INFORMATION D66 Hereditary factor VIII deficiency (hemophilia A) D68.311 Acquired hemophilia D67 Hereditary factor IX deficiency (hemophilia B) D68.39 Other Primary Thrombophilia D68.0 von Willebrand's disease D68.59 Other Primary Thrombophilia D68.0 von Willebrand's disease D68.59 Other Primary Thrombophilia D69.3 Hereditary factor XI deficiency (hemophilia C) D59.3 Hemolytic uremic syndrome D69.5 Paroxysmal nocturnal hemoglobinuria D69.5 Paroxysmal noctural hemoglobinuria D69.5 Paroxysmal noctural hemoglobinuria D89.5 Paroxysmal noctural hemoglobinuria D89	Plan #:			City, State, Zip:			
CRIVECAL INFORMATION D68.4 Hereditary factor IX deficiency (hemophilia P)	Group #:			Group #:			
D66 Hereditary factor VIII deficiency (hemophilia A)	Phone: Phone:						
D68.4 Acquired coagulation factor deficiency	CLINICAL INFORMATION						
□ D68.0 you Willebrand's disease □ D68.19 Other Primary Thrombophilia □ D68.1 Hereditary factor Xi deficiency (hemophilia C) □ D59.3 Hemolytic-uremic syndrome □ D59.5 Paroxysmal nocturnal hemoglobinuria Hemoglobinuria □ D59.5 Paroxysmal nocturnal hemoglobinuria □ D59.5 Paroxysmal noct	☐ D66 Hereditary factor VIII defic	iency (hemophilia A)		D68.311 Acquired hemophilia			
D58.1 Hereditary factor XI deficiency (hemophilia C)	☐ D67 Hereditary factor IX deficie	ncy (hemophilia B)		☐ D68.4 Acquired coagulation factor deficiency			
Other Code:	☐ D68.0 von Willebrand's disease			☐ D68.59 Other Primary Thrombophilia			
Hemophilia Severity:	☐ D68.1 Hereditary factor XI deficiency (hemophilia C)			☐ D59.3 Hemolytic-uremic syndrome			
Ship to: Patient Office Other:	☐ Other Code: Description:			☐ D59.5 Paroxysmal nocturnal hemoglobinuria			
Biologic Product Route Dose Directions Quantity Refills Brand:				Hemophilia Severity: vWD Type:			
Biologic Product Brand: IV	Needs by date: Ship to: Patient Office Other:						
Brand: □ IV □ month	(DRUG NAME) ORDERS – this se	ection may not be neede	d)				
Brand:	Biologic Product	Route	Dose	Directions	,	Refills	
Medications Route Dose Directions Quantity Refills Stimate *	Brand:	□IV					
Stimate Christian Christ	Medications	Route	Dose	Directions	Quantity	Refills	
□Amicar ® □Tablet □Syrup mg/kg □1 month □3 months □ Other: □ Sections Quantity Refills Flush Route Dose Directions Quantity Refills □ Saline 10mL □IV □ 3mL □ 5 mL □ 8efore and after infusion □1 month □3 months □ Heparin 10 units/mL □IV □ 3mL □ 5 mL □ After infusion □1 month □3 months Anaphylaxis Route Dose Directions Quantity Refills □ Diphenhydramine □ IV □PO □IM □ 25 mg □ 50 mg □ □ Pre-med: □ w/ ea. Infusion □ w/ ea. Infusion □ Epinephrine □ IM □ SQ □ Adult: 1:1000 0.3 mL □ PRN Anaphylaxis □ Once EpiPen (2 pack) □ IM □ SQ □ Peds 1:2000 0.3 mL □ Repeating Dose: □ □ Once SIGNATURE Date:	□Stimate ®	□NS	□150 mcg □300 mcg				
□ Other: Other:	□ A:						
Flush Route Dose Directions Quantity Refills Saline 10mL		□Tablet	ma/ka				
Saline 10mL	LIMITICAL -		mg/kg		□1 month		
Saline 10mL	☐ Other:		mg/kg		□1 month □3 months		
Heparin 10 units/mL	☐ Other:	□Syrup	Dose		☐1 month ☐3 months Quantity	Refills	
Anaphylaxis Route Dose Directions Quantity Refills Diphenhydramine	☐ Other:	□Syrup Route	Dose □ 3mL □ 5 mL	☐ Before and after infusion	□1 month □3 months Quantity □1 month	Refills	
Diphenhydramine	☐ Other: Flush ☐ Saline 10mL	□Syrup Route □IV	Dose □ 3mL □ 5 mL □ _	☐ Before and after infusion ☐	□1 month □3 months Quantity □1 month □3 months	Refills	
Diphenhydramine	☐ Other: Flush ☐ Saline 10mL ☐ Heparin 10 units/mL ☐ Heparin 100 units/mL	□Syrup Route □IV	Dose □ 3mL □ 5 mL □ □ 3mL □ 5 mL □	☐ Before and after infusion ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	□1 month □3 months Quantity □1 month □3 months □1 month □3 months		
Epinephrine	☐ Other: Flush ☐ Saline 10mL ☐ Heparin 10 units/mL ☐ Heparin 100 units/mL	Route	Dose □ 3mL □ 5 mL □ □ 3mL □ 5 mL □	☐ Before and after infusion ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐	□1 month □3 months Quantity □1 month □3 months □1 month □3 months □ uantity		
Nursing: Yes No	☐ Other: Flush ☐ Saline 10mL ☐ Heparin 10 units/mL ☐ Heparin 100 units/mL Anaphylaxis	Route IV Route Route	Dose □ 3mL □ 5 mL □ □ 3mL □ 5 mL □ □ Dose	☐ Before and after infusion ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐	□1 month □3 months Quantity □1 month □3 months □1 month □3 months □ unoths □ unoths □ unoths □ unoths □ unoths		
X Date:	☐ Other: Flush ☐ Saline 10mL ☐ Heparin 10 units/mL ☐ Heparin 100 units/mL Anaphylaxis ☐ Diphenhydramine	Route IV Route IV Route	Dose 3mL 5 mL 3mL 5 mL 3mL 5 mL 5 mL 25 mg 50 mg 40 mg 50 mg 5	☐ Before and after infusion ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐	□1 month □3 months Quantity □1 month □3 months □1 month □3 months Quantity □ w/ ea. Infusion □ □ Once		
X Date:	☐ Other: Flush ☐ Saline 10mL ☐ Heparin 10 units/mL ☐ Heparin 100 units/mL Anaphylaxis ☐ Diphenhydramine ☐ Epinephrine	Route IV Route IV Route IV PO IM	Dose 3mL 5 mL 3mL 5 mL 3mL 5 mL 5 mL 25 mg 50 mg 40 mg 50 mg 5	☐ Before and after infusion ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐	□1 month □3 months Quantity □1 month □3 months □1 month □3 months Quantity □ w/ ea. Infusion □ □ Once		
	☐ Other: Flush ☐ Saline 10mL ☐ Heparin 10 units/mL ☐ Heparin 100 units/mL Anaphylaxis ☐ Diphenhydramine ☐ Epinephrine EpiPen (2 pack)	Route IV Route IV Route IV PO IM IM SQ IM SQ	Dose 3mL 5 mL 3mL 5 mL 3mL 5 mL 5 mL 25 mg 50 mg 40 mg 50 mg 5	☐ Before and after infusion ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐	□1 month □3 months Quantity □1 month □3 months □1 month □3 months Quantity □ w/ ea. Infusion □ □ Once		
	☐ Other: Flush ☐ Saline 10mL ☐ Heparin 10 units/mL ☐ Heparin 100 units/mL Anaphylaxis ☐ Diphenhydramine ☐ Epinephrine EpiPen (2 pack) Nursing: ☐ Yes ☐ No A	Route IV Route IV Route IV PO IM IM SQ IM SQ	Dose 3mL 5 mL 3mL 5 mL 3mL 5 mL 5 mL 25 mg 50 mg 40 mg 50 mg 5	☐ Before and after infusion ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐	□1 month □3 months Quantity □1 month □3 months □1 month □3 months Quantity □ w/ ea. Infusion □ □ Once		
	☐ Other: Flush ☐ Saline 10mL ☐ Heparin 10 units/mL ☐ Heparin 100 units/mL Anaphylaxis ☐ Diphenhydramine ☐ Epinephrine EpiPen (2 pack) Nursing: ☐ Yes ☐ No A	Route IV Route IV Route IV PO IM IM SQ IM SQ	Dose 3mL 5 mL 3mL 5 mL 3mL 5 mL 5 mL 25 mg 50 mg 40 mg 50 mg 5	☐ Before and after infusion ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐	□1 month □3 months Quantity □1 month □3 months □1 month □3 months Quantity □ w/ ea. Infusion □ □ Once		
	☐ Other: Flush ☐ Saline 10mL ☐ Heparin 10 units/mL ☐ Heparin 100 units/mL Anaphylaxis ☐ Diphenhydramine ☐ Epinephrine EpiPen (2 pack) Nursing: ☐ Yes ☐ No A	Route IV Route IV Route IV PO IM IM SQ IM SQ	Dose 3mL 5 mL 3mL 5 mL 3mL 5 mL 5 mL 25 mg 50 mg 40 mg 50 mg 5	□ Before and after infusion □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	□1 month □3 months Quantity □1 month □3 months □1 month □3 months Quantity □ w/ ea. Infusion □ □ □ Once		

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