

## **Bleeding Disorder Enrollment Form**

Fax: 888-688-3593 Phone: 866-436-4376

Treatment Setting	Home by: ☐ Patient/caregiver ☐ Option Care nurse ☐ Other:				Referral date:			
	☐ MD office ☐ Option Care tre	☐ MD office ☐ Option Care treatment site ☐ Other:			Need by date/time:			
Patient	Name:			•				
Information	DOB: Gender: Language:							
Please type or print	Address:							
clearly.								
(OR fax demographic sheet)	City:			1				
Silecty	Home phone w/area code:			Alternate phone w/area code:				
	Caregiver name(s):			Caregiver relationship:				
	Emergency contact name: Phone:							
Medical Insurance	Primary insurance: Cardholder name/DOB: Cardholder employer:							
Information	ID#: Group#: Phone:							
Please attach a copy of card if possible.	Secondary insurance: Cardholder name/DOB: Cardholder employer:							
(OR fax front and back of	ID#: Phone:							
medical and prescription	Prescription card:	Prescription card: Phone:						
cards)	ID#:	Group#:	BIN#:	•		PCN#:		
Prescriber	Name:	0.000		•				
Information	Address: City: State: ZIP:							
(Unless on faxed Rx)		Cit	<b>1</b>	/	1	ZII	<u> </u>	
	Phone w/area code:	T	1	v/area code				
	NPI:	LIC:			name if CPNP or PA:			
Medical History	□ D66 - Hereditary Factor VIII Deficiency □ D67 - Hereditary Factor IX Deficiency □ D68.1 - Hereditary Factor XI Deficiency □ D68.2 - Hereditary Deficiency of other Clott				tting Foot	oro		
	□ D68.1 - Hereditary Factor XI Deficiency □ D68.2 - Hereditary Deficiency of other Clotting Factors □ D68.0 - von Willebrand's Disease □ D68.311 - Acquired Hemophilia							
	□ D68.8 - Other specified Coagulation Defects □ Other (ICD-10 Code and Description):							
	□ D68.9 - Coagulation Defect, unspecified  Baseline factor percent: Target joint(s) □ No □ Yes Inhibitor: □ No □ History □ Current BU/mL Inhibitor protocol:  DNR/Advance directive status: □ Received □ N/A □ Hep B □ Hep C □ HIV □ TB positive Date chest x-ray:  Drug allergies: Other conditions/other meds:							
	Vascular access: Peripheral Port Other: Weight:   kg   lbs   Height:   cm   in							
Dun a substitute								
Prescriptions	(							
(OR fax separately)	Factor VIII recombinant: ☐ Advate ☐ Helixate FS ☐ Kogenate FS ☐ Recombinate ☐ Xyntha ☐ Novoeight ☐ Adynovate ☐ Eloctate Plasma derived: ☐ Hemofil M ☐ Monoclate-P ☐ Other:							
*Target Dose (total	Target Dose and directions: Dispense qty: Refills:							
units/dose) plus or minus	Factor VIII and von Willebrand plasma derived: Alphanate Humate-P Koate-DVI Wilate Other:							
10% unless otherwise specified	Target Dose and directions    VWF   Factor VIII: Dispense qty: Refills:							
1,	Factor IX recombinant: ☐ BeneFix ☐ Rixubis ☐XINITY ☐ Alprolix ☐ Other:							
	Plasma derived: ☐ AlphaNine SD ☐ Mononine ☐ Other:							
							Refills:	
	Factor X: Coagadex Other:							
	Target Dose and directions: Dispense qty; Refills:  Factor XIII: ☐ Corifact ☐ Other:							
	Activated Prothrombin Complex Concentrates plasma derived:  Feiba VH Other:							
	Target Dose and directions: Dispense qty: Refills:							
	Prothrombin Complex Concentrates plasma derived: ☐ Bebulin VH ☐ Profilnine SD ☐ Other:							
	Target Dose and directions: Dispense qty: Refil						Refills:	
	Stimate 1 spray in □ one nostril □ each nostrilD					qty:	Refills:	
	Amicar □ syrup □ 500/1000 mg tab Dose and directions: Dispense qty: Refills: _						Refills:	
	Other (Continuous infusion, vancomycin, tranexamic acid, rituximab, EpiPen,etc)							
	Line care: ☐ Sodium chloride 0.9% 5 - 10 ml ☐ 3 - 5 ml Heparin (☐ 10 units/ml ☐ 100 units/ml) ☐ Other: ☐ Apply 30 - 60 minutes prior to access (☐ Emla 30 gram ☐ LMX 30 gram) ☐ Other:							
	Nursing orders: ☐ Skilled nurse to infuse/teach mixing, infusion, self-monitoring, other aspects of care:							
	Lab orders:							
	Supplies: All infusion and prevention supplies as needed and/or							
Prescriber	I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.							
Certification	Prescriber's signature required: Date:							

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CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws.