# Hemophilia

Referral Form

DELIVERIT™
Infusion & Specialty

Phone +1.832.939.8137
Fax: +1.832.939.8128

## Patient Demographic Information

(Or Attach Face Sheet from Patient Chart)

| Patient Name | | DOB | | Gender | Male ☐ Female ☐ | Weight | ____lbs ☐ kg ☐ |
|---|---|---|---|---|---|---|---|
| SSN | | Phone | | Allergies | | | |
| Address | | City | | State | | Zip Code | |

## Patient Insurance Information

(Or Attach Copies of Patient's Insurance Card)

| Primary Insurance | | Name of the Insured | | Relationship | |
|---|---|---|---|---|---|
| Member ID# | | Group # | | Insurance Phone # | |
| Secondary Rx Carrier | | Rx ID # | | Rx Group # | |

## Diagnosis and clinical informaton

**Diagnosis (ICD-10)**

- ☐ D66 Hereditary factor VIII deficiency
- ☐ D67 Hereditary factor IX deficiency
- ☐ D68.0 Von Willebrand's disease
- ☐ D68.311 Acquired hemophilia
- ☐ D68.318 Other hemorrhagic disorder due to intrinsic circulating anticoagulants, antibodies, or inhibitors
- ☐ D68.8 Other specified coagulation defects
- ☐ D68.9 Coagulation defect, unspecified
- ☐ D68.2 Hereditary deficiency of other clotting factors
- ☐ Other code:________________ Description:________________________________

**Nursing**

Specialty pharmacy to coordinate injection training/home health infusion nurse visit necessary ☐ **Yes** ☐ **No**

Site of Care: ☐ MD office ☐ Infusion Clinic ☐ Outpatient Health ☐ Home Health

Injection/Infusion training not necessary. Date training occurred: ________________________________

Reason: ☐ MD office training patient ☐ Pt already independent ☐ Referred by MD to alternate trainer

## Drug Therapy Information

| Medication | | | Strength | Dose & Directions | Quantity |
|---|---|---|---|---|---|
| ☐ Advate<br>☐ Adynovate<br>☐ Afstyla<br>☐ Alphanate<br>☐ AlphaNine<br>☐ Alprolix<br>☐ BeneFIX<br>☐ Coagadex<br>☐ Corifact<br>☐ Ceprotin | ☐ Hemofil-M<br>☐ Humate-P<br>☐ Idelvion<br>☐ Ixinity<br>☐ Jivi<br>☐ Koate-DVI<br>☐ Kovaltry<br>☐ Novoeight<br>☐ Nuwiq<br>☐ Obizur | ☐ Profilnine<br>☐ Recombinate<br>☐ Rixubis<br>☐ Thrombate III<br>☐ Tretten<br>☐ Vonvendi<br>☐ Wilate<br>☐ Xyntha | ______ IU/Kg | ☐ Prophylaxis: __________<br>Infuse ____ units (+/- 10%) slowIV push every ____ hours / days (circle one) for a total of____ doses needed for bleeding episodes.<br>☐ Minor Bleed: ____IU IV q ____ hr PRN<br>☐ Other: ______________________<br>☐ Immune Tolerance: ______________ | ☐ 1 month<br>☐ 3 month<br>☐ Other: ____<br>☐ 1 month<br>☐ Other: ____ |



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## Drug Therapy Information

| Medication | Strength | Dose & Directions | Quantity |
|---|---|---|---|
| ☐ Amicar | ☐ Tablet 500 mg<br>☐ Tablet 1000 mg<br>☐ Syrup 25% | ☐ Other: ______ | ☐ 1 month<br>☐ 3 month<br>☐ Other: ______<br>**Refill**<br>☐ 1 year<br>☐ Other: ______ |
| ☐ Altuviiio | ☐ 50 IU/kg<br>☐ ____ IU/KG | ☐ Prophylaxis: 50 IU/kg IV once weekly:<br>☐ On demand treatment: 50 IU/kg IV as needed for bleeding episodes. Contact your physician's office if bleeding does not resolve.<br>☐ Other: ______<br>☐ Weight: ____ kg | ☐ 1 month<br>☐ 3 month<br>☐ Other: ______<br>**Refill**<br>☐ 1 year<br>☐ Other: ______ |
| ☐ Esperoct | ☐ ____ IU/KG | ☐ Prophylaxis: ____IU/kg IVq every____days or ____ times per week<br>☐ On demand treatment: ____ IU/KG iv as needed for bleeding episodes. Contact your physician's office if bleeding does not resolve.<br>☐ Other: ______<br>☐ Weight: ____ kg | **Refill**<br>☐ 1 year<br>☐ Other: ______ |
| ☐ Hemlibra | ☐ 30 mg/mL<br>☐ 60 mg/0.4 mL<br>☐ 105 mg/0.7 mL<br>☐ 150 mg/1 mL | ☐ Initial dose: 3 mg/kg subcutaneously once weekly for 4 weeks<br>☐ Maintenance dose:<br>☐ 1.5 mg/kg subcutaneously every week<br>☐ 3 mg/kg subcutaneously every 2 weeks<br>☐ 6 mg/kg subcutaneously every 4 weeks<br>☐ Weight: ____ kg | ☐ 1 month<br>☐ 3 month<br>☐ Other: ______<br>**Refill**<br>☐ 1 year<br>☐ Other: ______ |
| ☐ NovoSeven RT | ☐ ____ mcg/kg | Infuse ____ mcg/kg slow IV push every ____ and /or ______<br>☐ Weight: ____ kg | ☐ 1 month<br>☐ 3 month<br>☐ Other: ______<br>**Refill**<br>☐ 1 year<br>☐ Other: ______ |


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## Drug Therapy Information

| Medication | Strength | Dose & Directions | Quantity |
|---|---|---|---|
| ☐ SevenFact | ☐ 1 mg<br>☐ 5 mg | **For Mild/Moderate bleeds:**<br>☐ 75 mcg/kg IV, repeat q 3 hours until hemostasis achieved OR<br>☐ Initial dose of 225 mcg/kg IV. May infuse 75 mcg/kg IV q 3 hour prn if hemostasis not achieved within 9 hours.<br>**For Severe bleeds:**<br>☐ 225 mcg/kg IV, followed if necessary 6 hours later wuth 75 mcgg/kgIV every 2 hours .<br>☐ Other: ____<br>Round to the nearest whole vial<br>☐ Weight: ____ kg | ☐ 1 month<br>☐ 3 month<br>☐ Other: ____<br>**Refill**<br>☐ 1 year<br>☐ Other: ____ |
| ☐ Stimate | ☐ 150 mcg | ☐ Weight <50 kg: Single spray in one nostril<br>☐ Weight >50 kg: Single spray in each nostril (2 sprays total)<br>☐ Other: ____ | ☐ 1 month<br>☐ 3 month<br>☐ Other: ____<br>**Refill**<br>☐ 1 year<br>☐ Other: ____ |
| ☐ Normal Saline | ☐ Other: ____ | **Access Device:**<br>☐ Port ☐ PICC ☐ PIV ☐ Butterfly<br>☐ Other: ____<br>☐ ____ ml every ____ | ☐ 1 month<br>☐ 3 month<br>☐ Other: ____<br>**Refill**<br>☐ 1 year<br>☐ Other: ____ |
| ☐ Heparin | ☐ 10 IU/mL<br>☐ 100 IU/mL | **Access Device:**<br>☐ Port ☐ PICC ☐ PIV<br>☐ Other: ____<br>☐ ____ ml every ____ | ☐ 1 month<br>☐ 3 month<br>☐ Other: ____<br>**Refill**<br>☐ 1 year<br>☐ Other: ____ |


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| Medication/Supplies | Route | Dose/Strength/Directions |
|---|---|---|
| **Catheter**<br>☐ PIV<br>☐ PICC<br>☐ PORT | IV | Catheter Care/Flush – Only on drug admin days – SASH or PRN to maintain IV access and patency<br>PIV – NS 5 mL (Heparin 10 units/mL 3-5 mL if multiple days)<br>PORT/PICC – NS 10 mL & Heparin 100 units/mL 3-5 mL, and/or 10 mL sterile saline to access port- a- cath |
| ☐ Diphenhydramine Oral | PO | ☐ 12.25 mg/kg (0-30 kg) ☐ 25 mg ☐ 50 mg (Over 30 kg) |
| ☐ Diphenhydramine 50 mg (Over 30 kg) | ☐ Slow IV<br>☐ IM | ☐ 1 mg/kg (under 15 kg) ☐ 12.5-50 mg (15-30 kg) ☐ 25 mg<br>☐ 50 mg (Over 30 kg)<br>May repeat in 3-5 minutes as needed (Max dose-50 mg) |
| ☐ Epinephrine **nursing requires** | ☐ IM<br>☐ SC | ☐ Adult 1:1000, 0.3 mL (>30 kg/>66 lbs)<br>☐ Peds 1:2000, 0.3 mL (15-30 kg/33-66 lbs)<br>☐ Infant 0.1 mL/0.1 mL, 0.1 mL (7.5-15 kg/16.5-33 lbs)<br>PRN severe allergic reaction – Call 911.<br>May repeat in 5-15 minutes as needed |
| ☐ Other: ______________ | ☐ Other: ________ | ☐ Other: ______________________ |

☐ Patient is interested in patient support programs

**STAMP SIGNATURE NOT ALLOWED**

Ancillary supplies and kits provided as needed for administration

## Prescriber Insurance Information

| Prescriber Name | | NPI# | | Office # | | Fax # | |
|---|---|---|---|---|---|---|---|
| Address | | City | | State | | Zip Code | |

☐ I Authorize DeliverIt specialty pharmacy to initiate Prior Authorizations on my behalf.

☐ DAW (Dispense as written).

*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 DeliverIt Group, this prescription shall be forwarded to an eligible pharmacy.*

**Date** ____________

**Prescriber's Signature**

X ______________________________



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