APEX SPECIALTY PHARMACY

BLEEDING DISORDERS

Benefit Investigation + Prior Authorization Support

Need by date: _____

Ship to:: ☐ Patient ☐ Provider
☐ Other _____

☐ Patient interested in support programs

PATIENT INFORMATION::

Patient Name:		Prescriber:	
Street Address:		NPI:	
City, State, Zip:		Group:	
Primary Phone:		Street Address:	
Phone #2:		City, State, Zip:	
Social Security:		Office Phone:	
Date of Birth:	/ /	Office FAX:	
Sex:	☐ M ☐ F	Primary Contact:	

PLEASE SEND INSURANCE CARD AND DEMOGRAPHIC INFORMATION

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: _____

Patient Clinical Information

Allergies: _____ Weight _____ lb/kg Height _____ in/cm

Nursing

Specialty Pharmacy to coordinate injection training/home health nurse visit as necessary? ☐ Yes ☐ No

Site care: ☐ MD Office ☐ Infusion Clinic ☐ Outpatient Health ☐ Home Health

Prescription Information

MEDICATION	STRENGTH	DOSE + DIRECTIONS	QUANTITY	REFILLS
☐ Advate ☐ Adynovate ☐ Afstyla ☐ Alphanate ☐ Eloctate ☐ Hemofil-M ☐ Koate-DVI ☐ Kogenate FS ☐ Kovaltry ☐ Monoclate-P ☐ Novoeight ☐ Nuwiq ☐ Recombinate ☐ Xyntha ☐ Feiba NF ☐ Humate-P ☐ Vonvendi ☐ Wilate	____ IU/kg	☐ Prophylaxis: _____ ☐ Immune Tolerance: _____ ☐ Breakthrough Bleed: Infuse ____ units (+/- 10%) slow IV push every ____ hours / days (circle one) for a total of ____ doses as needed for bleeding episodes. Contact your physician's office if bleeding does not resolve. Minor: ☐ ____ IU q ____ hr PRN ☐ Other: _____ Major: ☐ ____ IU q ____ hr PRN ☐ Other: _____	☐ 1 mo ☐ 3 mo ☐ _____	☐ 1 yr ☐ ____
☐ AlphaNine ☐ Alprolix ☐ Bebulin ☐ BeneFIX ☐ Idelvion ☐ IXINITY ☐ Profilnine ☐ Rixubis ☐ Rebinyn ☐ Corifact ☐ Tretten ☐ Ceprotin ☐ Thrombate III ☐ Coagadex				
☐ NovoSeven RT	____ mg	Infuse ____ mg slow IV push every ____ hours, and/or _____		
☐ Hemlibra	30mg/mL 60mg/0.4mL 105mg/0.7mL 150/1mL	☐ Initial dose: 3mg/kg subcutaneously once weekly for 4 weeks ☐ Maintenance dose: 1.5mg/kg subcutaneously once weekly Weight: ____ kg		
☐ Amicar Tablet ☐ Amicar Syrup	____ mg/kg			
☐ Stimate	☐ 150mcg ☐ 300mcg	☐ Weight <50kg: Single spray in **one** nostril ☐ Weight >50kg: Single spray in **each** nostril (total of 2 sprays)		
☐ Normal Saline		ACCESS DEVICE: ☐ Port ☐ PICC ☐ PIV ☐ Butterfly ☐ Other: ____ ml every _____		
☐ Heparin	☐ 10 IU/ml ☐ 100 IU/ml	____ ml every _____		
☐ Epinephrine	☐ 0.3mg ☐ 0.15mg	☐ PRN anaphylaxis ☐ Other: _____	____ Pens	

Ancillary supplies and kit provided as needed for administration

PHYSICIAN SIGNATURE REQUIRED || STAMP SIGNATURE NOT ALLOWED

PRESCRIBER SIGNATURE _____ _____ DATE ____ / ____ / ____

PRODUCT SUBSTITUTION PERMITTED DISPENSE AS WRITTEN

IF YOU RECEIVE THIS MESSAGE IN ERROR, PLEASE CONTACT THE SENDER IMMEDIATELY AND THEN DESTROY THE MATERIALS.
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