

Hemophilia Referral Form



Phone: 808-533-8887
 Fax: 808-533-1888
 E-Prescribing Available

Attention: _____ Need By Date: _____ First Ship To: Patient Physician

Patient	Patient Name: _____ DOB: _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Address: _____ City: _____ State: _____ Zip: _____
	Home#: _____ Work #: _____ Cell#: _____ Best time to call: <input type="checkbox"/> AM <input type="checkbox"/> PM
	Soc. Sec #: _____ Ethnicity: _____ Primary Language: _____
	Comorbidities: _____ Height: _____ Weight: _____ Date: _____
	Allergies: _____ <input type="checkbox"/> NKDA

Provider	Physician Name: _____ Practice Name: _____ State Lic#: _____ DEA#: _____
	Address: _____ City: _____ State: _____ Zip: _____ NPI#: _____
	Phone#: _____ Fax#: _____ Nurse/Key Office Contact: _____ Ext.: _____

Insurance	Primary Insurance: _____ ID: _____ Phone: _____
	Secondary Insurance: _____ ID: _____ Phone: _____

* Please provide a copy of the insurance card (front and back) and MEDICATION LIST

Clinical Info	Please include ICD-10 code and diagnosis name <input type="checkbox"/> D66 Type A (FACTOR VIII deficiency) <input type="checkbox"/> D67 Type B (factor IX deficiency) <input type="checkbox"/> D68.1 Type C (factor XI deficiency) <input type="checkbox"/> D68.0 Von Willebrand Disease Check type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> G68.2 Other Clotting Disease <input type="checkbox"/> D68.4 Acquired Coagulation Disease <input type="checkbox"/> D68.9 Other Coagulation Disorder <input type="checkbox"/> Other: ICD-10 _____ Diagnosis _____	Inhibitor: <input type="checkbox"/> Current _____ BU <input type="checkbox"/> History <input type="checkbox"/> No Severity: Circulating Factor Level: _____ % <input type="checkbox"/> Severe (<1% activity) <input type="checkbox"/> Moderate (1-5% activity) <input type="checkbox"/> Mild (>5% activity) Target Joints: <input type="checkbox"/> No <input type="checkbox"/> Yes: _____ Nursing needed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> TBD Agency of choice: _____ If no, reason: <input type="checkbox"/> Trained to self-administer <input type="checkbox"/> MD office to administer to patient <input type="checkbox"/> Home health nursing already coordinated Agency: _____
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Prescription

Medication	Dose/Strength	Directions	Quantity	Refill
<input type="checkbox"/> Advate <input type="checkbox"/> Alphanate <input type="checkbox"/> Helixate <input type="checkbox"/> Hemofil-M <input type="checkbox"/> Koate-DVI <input type="checkbox"/> Kogenate FS <input type="checkbox"/> Monoclate-P <input type="checkbox"/> Recombinate <input type="checkbox"/> Xyntha <input type="checkbox"/> Corifact <input type="checkbox"/> Ceprotin	<input type="checkbox"/> Alphanine <input type="checkbox"/> Bebulin <input type="checkbox"/> BeneFIX <input type="checkbox"/> Mononine <input type="checkbox"/> Profilnine <input type="checkbox"/> Rixubis <input type="checkbox"/> Humate-P <input type="checkbox"/> Wilate <input type="checkbox"/> Feiba NF <input type="checkbox"/> Novoseven RT <input type="checkbox"/> Thrombate III	<input type="checkbox"/> Prophylaxis: _____ <input type="checkbox"/> Immune Tolerance: _____ <input type="checkbox"/> Breakthrough Bleed <input type="checkbox"/> Infuse _____ units (+/- 10%) slow iv push every _____ hours/days (circle one) for a total of _____ doses as needed for bleeding episodes. Contact your physicians office if bleeding does not resolve. Minor: <input type="checkbox"/> _____ IU q _____ hr PRN <input type="checkbox"/> Other: _____ Major: <input type="checkbox"/> _____ IU q _____ hr PRN <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> Amicar tablet <input type="checkbox"/> Amicar syrup	_____ mg/kg	<input type="checkbox"/> Single spray one nostril < 50 kg <input type="checkbox"/> Single spray in each nostril >50 kg (2 sprays total)		
<input type="checkbox"/> Stimate	<input type="checkbox"/> 150 mcg <input type="checkbox"/> 300 mcg			
<input type="checkbox"/> Normal Saline <input type="checkbox"/> Heparin <input type="checkbox"/> 10 units/ml <input type="checkbox"/> 100 units/ml <input type="checkbox"/> Other: _____	Access Device: <input type="checkbox"/> Port <input type="checkbox"/> PICC <input type="checkbox"/> PIV <input type="checkbox"/> Butterfly <input type="checkbox"/> Other: _____	_____ mL		
<input type="checkbox"/> Epi-Pen <input type="checkbox"/> Epi-Pen Jr. <input type="checkbox"/> Other: _____	<input type="checkbox"/> One Pen <input type="checkbox"/> Two Pens <input type="checkbox"/> Other: _____	<input type="checkbox"/> PRN Anaphylaxis <input type="checkbox"/> Other: _____		

Interchange is mandated unless practitioner writes the words "BRAND MEDICALLY NECESSARY". _____

Physicians Signature(Required by Law): _____ Date: _____

I authorize The Honolulu Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Confidentiality statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPPA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing the information (other than to the intended recipient) or copying the information. If you received this communication in error, please notify the sender immediately by calling 808-533-8887 or by emailing help@thehonolulu-pharmacy.com to obtain instructions as to the proper destruction of the transmitted material. Thank you.