Hemophilia Referral Form

THE HONOLULU PHARMACY
COMPOUNDING PHARMACY & SPECIALTY PHARMACY

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: ☐ Male ☐ Female
Address: _____ City: _____ State: _____ Zip: _____
Home#: _____ Work #: _____ Cell#: _____ Best time to call: ☐ AM ☐ PM
Soc. Sec #: _____ Ethnicity: _____ Primary Language: _____
Comorbidities: _____ Height: _____ Weight:_____ Date:_____
Allergies: _____ ☐ 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
☐ D66 Type A (FACTOR VIII deficiency)
☐ D67 Type B (factor IX deficiency)
☐ D68.1 Type C (factor XI deficiency)
☐ D68.0 Von Willebrand Disease
Check type: ☐ 1 ☐ 2 ☐ 3
☐ G68.2 Other Clotting Disease
☐ D68.4 Acquired Coagulation Disease
☐ D68.9 Other Coagulation Disorder
☐ Other: ICD-10_____Diagnosis_____

Inhibitor: ☐ Current _____BU ☐ History ☐ No
Severity: Circulating Factor Level: _____%
☐ Severe (<1% activity) ☐ Moderate (1-5% activity)
☐ Mild (>5% activity)
Target Joints: ☐ No ☐ Yes: _____
Nursing needed? ☐ Yes ☐ No ☐ TBD
Agency of choice: _____
If no, reason: ☐ Trained to self-administer
☐ MD office to administer to patient
☐ Home health nursing already coordinated
Agency: _____

Prescription

Medication		Dose/Strength	Directions	Quantity	Refill
☐ Advate ☐ Alphanate ☐ Alprolix ☐ Elocatate ☐ Helixate ☐ Hemofil-M ☐ Idelvion ☐ Koate-DVI ☐ Kogenate FS ☐ Kovaltry ☐ Monoclate-P ☐ Recombinate ☐ Xyntha	☐ Afstyla ☐ Alphanine ☐ Bebulin ☐ BeneFIX ☐ Mononine ☐ Profilnine ☐ Rixubis ☐ Humate-P ☐ Wilate ☐ Feiba NF ☐ Novoseven RT ☐ Thrombate III	_____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 physicians office if bleeding does not resolve. Minor: ☐ _____IU q _____hr PRN ☐ Other: _____ Major: ☐ _____IU q _____hr PRN ☐ Other: _____	☐ 1 month ☐ 3 months ☐ Other:___	☐ 1 year ☐ Other:___
☐ Amicar tablet ☐ Amicar syrup		_____mg/kg			
☐ Stimate		☐ 150 mcg ☐ 300 mcg	☐ Single spray one nostril < 50 kg ☐ Single spray in each nostril >50 kg (2 sprays total)		
☐ Normal Saline	Access Device: ☐ Port ☐ PICC ☐ PIV ☐ Butterfly ☐ Other: _____	_____ml			
☐ Heparin ☐ 10 units/ml ☐ 100 units/ml ☐ Other: _____		_____ml			
☐ Epi-Pen ☐ Epi-Pen Jr.		☐ One Pen ☐ Two Pens ☐ Other: _____	☐ PRN Anaphylaxis ☐ Other: _____		
☐ 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.