

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"/> Alprolix <input type="checkbox"/> Elocatate <input type="checkbox"/> Helixate <input type="checkbox"/> Hemofil-M <input type="checkbox"/> Idelvion <input type="checkbox"/> Koate-DVI <input type="checkbox"/> Kogenate FS <input type="checkbox"/> Kovaltry <input type="checkbox"/> Monoclate-P <input type="checkbox"/> Recombinate <input type="checkbox"/> Xyntha	<input type="checkbox"/> Afstyla <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"/> IU/kg <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"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> Stimate	<input type="checkbox"/> 150 mcg <input type="checkbox"/> 300 mcg	<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"/> 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.

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