ENVISIONSPECIALTY

Bleeding Disorder Enrollment Form

Fax: 877- 309-0687 Call: 877-437-9012

Date Fill Needed:

____/____/______

Patient Information

Patient Name: ____________________________________
Date of Birth: ____________________ Gender: Male or Female
Address: ____________________________________
City: ______________ State: __________ Zip: ____________
Home Phone: ______________ Work Phone: ______________
Cell Phone: ____________ E-mail: ____________________

Please attach copy of front and back of patient's insurance card(s) if applicable

Insurance Company Name: ______________________________
Insurance Company Phone: ______________________________
Policy holder: ______________________________
Policy holder Employer: ______________________________
Relationship to Patient: ______________________________
Prescription Coverage ID# ____________ Group# ____________
RxBIN: ________________ RxPCN: ________________

Prescriber Information

Hemophilia Treatment Center Affiliation: ____________________
Patient's Coordinator Contact: ____________________
Practice/Organization Name: ____________________
Physician Name: ____________________
Address: ______________________________
City: ________________ State: ____________ Zip: ________
Phone#: ________________ Fax#: ________________
DEA# ________________ NPI# ________________
License#: ______________ Medicaid UPIN#: ______________
Shipment Address: ______________________________
Attn: ______________________________
City: ________________ State: ____________ Zip: ________

If shipped to the physician's office, physician accepts on behalf of patient for administration in office

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Clinical Information and Prescription

Primary Diagnosis

☐D66.0 Hemophilia A (Factor VIII deficiency) ☐D67.0 Hemophilia B (Factor IX Deficiency)
☐D68.1 Hemophilia C (Factor XI Deficiency) ☐D68.0 von Willebrand disease; type ☐1 ☐2 ☐3
☐D68.2 Hereditary Deficiency (Factor X Deficiency) ☐D68.2 Hereditary Deficiency (Factor XIII Deficiency)
☐______ Other: ______________________________

Severity: ☐Mild (>5% Activity) ☐Moderate (1-5% activity) ☐Severe (<1% activity)
Target Joints? ☐ No ☐ Yes: ______________________________
Inhibitor Activity: ☐None ☐Historical ☐Current: __________ B.U. **Bypassing Agent Use:** ☐None ☐Yes: __________
Patient Height: ________ Weight: ________ Date Taken: ______ Allergies: ____________________
Current Medications: ______________________________
Co-Morbidities: ______________________________
Vascular Access: ☐ Peripheral IV ☐Port-a-cath ☐PICC ☐Central line ☐Other: ______________
Infusion by: ☐Patient ☐Caregiver ☐Nursing Agency: ______________ ☐Other: ____________

Factor VIII

Recombinant: ☐ Advate ☐ Helixate FS ☐ Kogenate FS ☐ Kovaltry ☐ Novoeight ☐ Nuwiq ☐ Recombinate ☐ Xyntha

Long Acting Recombinant: ☐ Advnovate ☐ Afstyla ☐ Eloctate

Plasma Derived: ☐ Hemofil M ☐ Koate DVI

Factor IX

☐ Alprolix ☐ Alphanine SD ☐ Benefix ☐ Bebulin ☐ Idelvion
☐ Ixinity ☐ Mononine ☐ Profilnine SD ☐ Rebinyn ☐ Rixubis

Anti-Inhibitor Products:

☐ Feiba VH & NF ☐ Novoseven RT ☐ Novoseven

Factor X:

☐ Coagadex

Factor XIII:

☐ Tretten ☐ Corifact

Antithrombotic Factor / von Willebrand Factor Complex

☐ Alphanate ☐ Humate-P ☐ Thrombate III ☐ Wilate vonWillebrand ☐ Vonvendi

Dosing Regimen	Prophylaxis	Minor bleed	Moderate Bleed	Severe Bleed
Dose in Units (mg for Factor VII)				
Number of Doses per month to dispense				

Flush Orders:

Before Factor: ☐ NaCl 0.9% (NS) ____ml ☐Heparin 10u/ml ____ml ☐Heparin 100u/ml ______ml
After Factor: ☐ NaCl 0.9% (NS) ____ml ☐Heparin 10u/ml ____ml ☐Heparin 100u/ml ______ml

Supplies requested: ______________________________

Refills Authorized: ☐ 0 ☐1 ☐2 ☐3 ☐ 6 mos ☐1 yr ☐Other: ______________

Physician Signature (no stamps): ______________________ **Date:** __________