Hemophilia Enrollment Form

Date: __________ Needs by Date: _________

Fax Referral To: 866-811-7450

Phone: 866-792-2731

Ship to: ☐ Patient ☐ Office ☐ Other: ____________________

PATIENT INFORMATION

(Complete the following or send patient demographic sheet)

Patient Name: ____________________
Address: ____________________
City, State, Zip: ____________________
Home Phone: ____________________
Alternate Phone: ____________________
Last Four of SS #: __________ Primary Language: __________
Date of Birth: __________ Gender: __________

PRESCRIBER INFORMATION

Prescriber's Name: ____________________
State License #: __________ UPIN: __________
DEA #: __________ NPI #: __________
Group or Hospital: ____________________
Address: ____________________
City, State Zip: ____________________
Phone: __________ Fax: __________
Contact Person: __________ Phone: __________

INSURANCE INFORMATION (*Please copy and attach the front and back of insurance and prescription drug card*)

Prescription Card: Name of Insurer: __________ ID#: __________ BIN: __________ PCN: __________ Group: __________
Primary Insurance: Subscriber: __________ ID#: __________ Name of Insurer: __________ Phone: __________
Secondary Subscriber: __________ ID#: __________ Name of Insurer: __________ Phone: __________

STATEMENT OF MEDICAL NECESSITY

Diagnosis:

☐ 286.0 Hemophilia A (Factor VIII Deficiency) ☐ 286.1 Hemophilia B (Factor IX Deficiency)
☐ 286.2 Hemophilia C (Factor XI Deficiency) ☐ 286.3 Other Clotting Disorder
☐ 286.4 von Willebrand Disease ☐ 286.7 Acquired Coagulation
Type: ☐1 ☐2 ☐3 ☐ 286.9 Other Coagulation
☐ 286.5 Hemorrhagic Disorders ☐ __________
• Date of Diagnosis: __________

Home Health Nursing Coordination:

• Specialty Pharmacy to coordinate home health nursing visit as necessary.
☐Yes ☐No *Agency of __________
• Home health nursing visit coordination is not necessary.
Date of treatment start: __________
Reason: ☐ MD office trained patient ☐ Home health nursing already

Pertinent Medical/Bleeding History:

• Severity: ☐ Severe (<1% activity) ☐ Moderate (1-5% activity)
☐ Mild (>5% activity) • Circulating Factor: ______ %
• Inhibitor: ☐ No ☐ Historical ☐ Current: ______ B.U.
• Target Joints: ☐ No ☐ Yes • Explain: __________
• Protocols: ☐ 1° Prophylaxis ☐ 2° Prophylaxis ☐ Preventitive
☐ Immune tolerance: __________ ☐ Other: ______
• Start Date: ______ • End Date: ______
• Vascular Access Method: ☐ peripheral ☐ central ☐ Other: ______
• Flushing Protocol: Please state flushing protocol: __________
____
• Patient Weight: ______ kg/lbs • Allergies: __________
• Concomitant Medications: __________

PRESCRIPTION INFORMATION

MEDICATION	DOSE	THERAPY REGIMEN	QTY	REFILL
Factor VIII Concentrates & VWD				
☐ Advate	Target Dose: ______ IU/kg	Therapy Regimen: ☐ Prophylaxis ______ / week ☐ Immune tolerance: ☐ Breakthrough bleed: ☐ Minor: ______ ☐ Major: ______		
☐ Alphanate				
☐ Helixate FS				
☐ Hemofil M				
☐ Koate-DVI				
☐ Kogenate FS				
☐ Monarch-M				
☐ Monoclate-P				
☐ Recombinate				
☐ ReFacto				
☐ Xyntha				
☐ Humate P				
☐ Wilate				
Factor IX Concentrates				
☐ BeneFIX	Target Dose: ______ IU/kg	Therapy Regimen: ☐ Prophylaxis ______ / week ☐ Immune tolerance: ______ ☐ Breakthrough bleed: ☐ Minor: ______ ☐ Major: ______		
☐ Mononine				
☐ Alphanine SD				
☐ Bebulin VH				

MEDICATION	DOSE	THERAPY REGIMEN	QTY	REFILL
Anti-Inhibitor Products				
☐ Feiba VH	Target Dose: ______ IU/kg	Therapy Regimen: ☐ Prophylaxis ______ / week ☐ Immune tolerance: ______ ☐ Breakthrough bleed: ☐ Minor: ______ ☐ Major: ______		
☐ NovoSeven RT				
Other				
☐ Amicar tablet	Target Dose: ____mg/kg	Therapy Regimen: ☐ Breakthrough bleed: ☐ Minor: ______ ☐ Major: ______		
☐ Amicar syrup				
☐ Stimate	☐ 150mcg ☐ 300mcg	☐Single spray in one nostril < 50kg ☐Single spray in both nostrils > 50kg (total of 2 sprays)		
Miscellaneous				
☐ Epipen®		Use as directed.	2-Pak kit	PRN
Concentrates of Antithrombotic Factors				
☐ Thrombate III	Target Dose: ______IU/kg	Therapy Regimen: ☐ Breakthrough bleed: ☐ Minor: ______ ☐ Major: ______		

Ancillary Supplies and Kits Provided as Needed for Administration.

X ____________________
PRODUCT SUBSTITUTION PERMITTED (Date)

X ____________________
DISPENSE AS WRITTEN (Date)

CVS Caremark is an independent specialty pharmacy management company and does not provide Florida Blue products or services. CVS Caremark is solely responsible for the administration of specialty pharmacy benefits. Florida Blue is a trade name of the Blue Cross and Blue Shield of Florida Inc., an Independent Licensee of the Blue Cross and Blue Shield Association.

IMPORTANT NOTICE: *This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee. Florida Blue Hemophilia 082812*