Hemophilia Referral Form

University Hospitals
Home Care Services

4510 Richmond Road
Warrensville Heights, OH 44128
Phone: 800-552-8442
Fax: 216-201-5127

Please complete each section of the referral form below and fax along with a copy (front and back) of all of the patient's pharmacy and medical insurance cards, the patient's demographic face sheet, and any relevant clinical notes/documents.

Prescriber Info.

Prescriber: ______________________ **NPI:** ______________________

Phone: ______________ **Fax:** ______________ **Office Contact:** ______________

Address: ____

Patient Information

Name: ______________________ **DOB:** ______________ ☐**M** ☐**F**

Address: ____

Phone: ______________ **2nd Phone:** ______________ **MRN:** ______________

Primary Language: ______________ **Functional Limitations:** ______________

Clinical Information

Primary Diagnosis:

2.86 Hemophilia A (Factor VIII Deficiency).	**286.1 Congenital Factor IX Disorder (Hemophilia B).**	**286.2 Congenital Factor XI Disorder (Hemophilia C).**
☐ *D66 Hereditary Factor VIII.*	☐ *D67 Hereditary Factor IX Deficiency.*	☐ *D68.1 Hereditary Factor XI Disorder.*
286.9 Coagulation Defect NEC/NO.	**286.4 Von Willebrand Disease**	**Other ICD-10:**
☐ *D68.8 Other Specified Coagulation Defects.*	☐ *D68.1 Hereditary Factor XI Disorder.*	☐ ______________

FVIII/FIX assay:__________ U/ml **FXIII/FIX activity:** __________% **Inhibitor Titer:** __________BU/ml **Date:** __________

Allergies: ______________________________ **Latex allergy?** ☐Yes ☐No

Prior treatments & reason for discontinuation: ______________________________

Patient's first dose? ☐Yes ☐No (*If no, Treatment start date:* __________ *Date of last dose:* __________)

Method of Administration: ☐ PICC ☐ Port ☐IV Catheter ☐Central Line ☐Butterfly ☐ Other ______________

Medications

☐ Advate	☐ BeneFIX	☐ Idelvion	☐ NovoSeven RT	☐ Stimate
☐ Adynovate	☐ Corifact	☐ IXINITY	☐ Nuwiq	☐ Tratten
☐ Afstyla	☐ Eloctate	☐ Koate DVI	☐ Obizur	☐ Wilate
☐ Alphanate	☐ Feiba	☐ Kogenate FS	☐ Profilnine	☐ Xyntha
☐ AlphaNine	☐ Helixate	☐ Monoclate-P	☐ Rebinyn	☐ Other
☐ Alprolix	☐ Hemofil	☐ Mononine	☐ Recombinate	__________
☐ Bebulin	☐ Humate-P	☐ Novoeight	☐ Rixubis	

☐ 0.9% sodium chloride 5-10mL pre/post infusion and PRN

☐ Heparin 10 Units/mL 5mL post infusion and PRN

☐ Heparin 100 Units/mL 5mL post infusion and PRN

☐ Standard supplies for administration as requested

☐ Sharps container

☐ Other ______________________

Prescription Information

Prophylactic Dosing: Dose: __________ Frequency: __________ Refills: __________ Goal: __________

☐ Dispense 30-day supply based on frequency ☐ Dispense ________ doses for a 30-day supply

Episodic Dosing: Bleeding Dose: ______________________________

☐ Dispense 30-day supply based on frequency ☐ Dispense ________ doses for a 30-day supply

Prescriber Signature

My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize Home Care and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide infusion-related nursing services and supplies in conjunction with the therapy prescribed above.

Signature: ______________________________ **Date:** ______________

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