vitalcare of SOUTH DALLAS

Hemophilia Referral Form

P: 945.212.3707 | **F:** 866.790.3580

☐ Home Infusion ☐ Alternate Site of Care

PATIENT INFORMATION

Patient Name: _____
Date of Birth: ____ /____ / ____ ☐ Male ☐ Female
SSN: ____ -____ - ____
Physical Address: _____
City: _____ State: _____ Zip: _____

Phone: (____) - ____ - _____ Emerg. Contact: _____
Email: _____ Emerg. Phone: (____) -____ -_____
Preferred method of contact: ☐ Phone ☐ Email
Height: _____ in Weight: _____ lb Date: ____ /____ / ____
Allergies: Medications: *(Please attach additional pages if necessary)*

PRESCRIPTION BENEFITS INFORMATION *(Please attach front and back of insurance card)*

Plan name: _____ ID#: _____ Group #: _____ RxBIN: _____ RxPCN: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Contact: _____
Clinic/Hospital Affiliation: _____

Phone: (____) - ____ - _____
Fax: (____) - ____ - _____
License #: _____
NPI #: _____
Medicaid Provider #: _____

CLINICAL INFORMATION

Primary Diagnosis: _____
Diagnosis Code: _____
Secondary Diagnosis: _____
Diagnosis Code: _____

Bleeding Disorder Type:
☐ A ☐ B ☐ vWD ☐ Other:_____

Inhibitors:
☐ Yes ☐ No

Severity:
☐ Mild ☐ Moderate ☐ Severe ☐ Type vWD:_____

Is patient followed at a Hemophilia Treatment Center?
☐ Yes ☐ No *If Yes, Where?*_____

IV Access:
☐ Peripheral ☐ Port ☐ Central Line ☐ PICC Line

Medical Equipment:
☐ Ambulatory IV Infusion Pump ☐ Infusion Pump Pole
☐ Subcutaneous Infusion Pump ☐ Other: _____

MEDICATION

☐ Advate®	☐ Hemofil®	☐ NovoSeven®RT
☐ Adynovate®	☐ Humate-P®	☐ Nuwiq®
☐ Afstyla®	☐ Idelvion®	☐ Obizur®
☐ Alphanate®	☐ IXINITY®	☐ Rebinyn®
☐ AlphaNine®SD	☐ Jivi®	☐ Recombinate®
☐ Alprolix®	☐ Koate®DVI	☐ Rixubis®
☐ BeneFIX®	☐ Kogenate®FS	☐ Stimate®
☐ Corifact®	☐ Kovaltry®	☐ Tretten®
☐ Eloctate®	☐ Monoclate-P®	☐ Vonvendi®
☐ Feiba®	☐ Mononine®	☐ Wilate®
☐ Hemlibra®	☐ Novoeight®	☐ Xyntha®

☐ Other: _____

Infuse _____ units IV _____ for prophy
Dispense: _____ *(include dosing schedule)*

Infuse _____ units IV _____ as needed for PRN
Dispense: _____ *(include dosing schedule)*

REFILL: _____

Infusion Training

Infusion training provided by ☐ Prescriber's Office ☐ Specialty Pharmacy ☐ Other: _____

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

PRESCRIBER SIGNATURE *(Stamp signature not allowed, physician signatured required)*

_____	_____	_____
Product Selection Permitted	**Dispense as Written**	**Date**

SHIPPING INFORMATION

Ship to: ☐ Patient ☐ Physician/Clinic Date Shipment Needed By: ____ /____ / ____

PLEASE INCLUDE ALL MEDICAL RECORDS & LAB VALUES
PLEASE FAX TO 866.790.3580

PHONE: 945.212.3707
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