

# Hemophilia Health Services referral form



Patient info	Patient name:		Phone #:
	Address:		
	DOB:	Sex:	Marital status:
	Patient representative:		

Medicaid	Complete this section for Medicaid patients ONLY	
	Last 4 digits of SS#:	OR Medicaid ID #

Primary insurance	<b>Primary insurance:</b>		Phone:
	Name of insured:		Relationship:
	Last 4 digits of insured SS#:	DOB:	Employer:
	Group #:	Policy #:	Member #:
	<b>Prescription/Drug card company:</b>		Phone:
	Rx BIN #:	Group #:	Policy ID:

Secondary insurance	<b>Secondary insurance:</b>		Phone:
	Name of insured:		Relationship:
	Last 4 digits of insured SS#:	DOB:	Employer:
	Group #:	Policy #:	Member #:
	<b>Prescription/drug card company:</b>		Phone:
	Rx BIN #:	Group #:	Policy ID:

Clinical	Bleeding disorder type: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> vWD <input type="checkbox"/> Other _____		Height:	Weight:	
	Severity: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Type vWD _____				
	IV access: <input type="checkbox"/> PIV/butterfly <input type="checkbox"/> PICC <input type="checkbox"/> Implanted port <input type="checkbox"/> Central line			Inhibitor: <input type="checkbox"/> No <input type="checkbox"/> Yes ( ___ B.U.)	
	Target joint(s): <input type="checkbox"/> No <input type="checkbox"/> Yes Location: _____			Allergies:	
Additional clinical information:					

201 Great Circle Road | Nashville, TN 37228 | Phone: 1 866 712-5007 | Fax: 1 800 330-0756

Please fax your completed form, along with a copy of the front and back of the patient's insurance ID cards, to: 1 800 330-0756.

Questions? Please call 1 866 712-5007.

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Patient info

Patient name:	Phone #:
Address:	
DOB:	

**Clotting factor orders - Complete this form OR attach prescription below.**

Brand name:	Dose:	Qty:	Frequency:
Brand name:	Dose:	Qty:	Frequency:
Dosage: Mild units/kg _____		Severe units/kg _____	
Prophylaxis: Dispense _____ doses/week for a duration of _____ months			
Episodic: Dispense _____ doses for mild / _____ doses for severe			

**Ancillary medications/supplies/nursing**

<input type="checkbox"/> Amicar® _____ mg Directions:	<input type="checkbox"/> Heparin _____ units/mL _____ mL flush
<input type="checkbox"/> Stimate® 1.5 mg/mL spray in <input type="checkbox"/> each <input type="checkbox"/> both nostril(s), as directed	<input type="checkbox"/> Saline _____ mL _____ mL flush
<input type="checkbox"/> Emla® Apply topically as needed to IV site 30 - 60 minutes prior to insertion prn. _____	
<input type="checkbox"/> LMX™ Apply topically as needed to IV site 30 - 60 minutes prior to insertion prn. _____	
<input type="checkbox"/> Cryo/Cuff® to be applied to affected site/joint prn _____. Site _____	
<input type="checkbox"/> Skilled nursing visits to be provided for infusions <input type="checkbox"/> Skilled nursing visits to be provided for teaching	
<input type="checkbox"/> Other:	

Prescription

Prescriber name and title:		Office contact:	
Address:			
Phone #:		Fax #:	
License #:	UPIN #:	NPI #:	DEA #:

Attach prescription form here.

# Refills \_\_\_\_\_ Refill x \_\_\_\_\_ year/month

Date \_\_\_\_\_ Time \_\_\_\_\_

Prescriber signature: \_\_\_\_\_

Dispense as written

Substitution allowed

(Physician attests this is his/her legal signature. NO STAMPS.) By signing, I certify that the above therapy is medically necessary.  
If shipped to physician's office, physician accepts on behalf of patient for administration in office

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Stimate is a registered trademark of CSL Behring.  
Emla is a registered trademark of the AstraZeneca group of companies.  
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Cryo/Cuff is a trademark of Aircast Inc.  
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