For assistance, contact your pharmacy representative: ______________________ Phone:______________________ **(For providers only)**

PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY. ALL OF OUR PHARMACY LOCATIONS ACCEPT ELECTRONIC PRESCRIPTIONS.

Note: This form is intended for prescriber use only, if faxed, the fax must come from MD office or hospital **(may not be faxed by patient)**.

Hemophilia & Bleeding Disorders

Prescription/Pharmacy Intake Form

Pharmacy: ______________________

Pharmacy Fax: ______________________ Pharmacy Phone: ______________________

Date Needed: __________ **Ship To:** ☐Prescriber's Office ☐Patient's Home ☐Other: ______________________

PATIENT INFORMATION

Patient name: ______________________ DOB: __________ ☐Male ☐Female

Address: ______________________

City: ______________________ State: __________ Zip code: __________

Phone # (Daytime): ______________________ Phone # (Evening): ______________________

E-mail Address: ______________________ Case Manager: ______________________

Insurance provider **(Please include copy of front and back of card)**: ______________________

ID #: __________ Policy/Group #: __________ Phone #: __________ ☐Patient is eligible for Medicare

Name of Insured: ______________________ Employer: ______________________

Relationship to Patient: ☐Self ☐Other: __________ Prescription Card: ☐Yes ☐No Carrier: __________ Policy/Group #: __________

Will there be access to anaphylactic medications and oxygen at the administration site? ______________________

CLINICAL ASSESSMENT – Please complete ALL sections to avoid delays in filling prescription.

☐Patient is new to therapy ☐Therapy continuation Start date: __________

Primary Diagnosis Code and Condition (ICD-10): ______________________ Date of Diagnosis: __________

Other Diagnosis/Conditions: ______________________ Current Height: __________ Current Weight: __________

Allergies: ______________________

Clinical Features: Circulating factor level % __________ Severity ☐Mild(>5% activity) ☐Moderate (1-5% activity) ☐Severe (<1% activity)

Joints affected ☐No ☐Yes (specify) __________ Inhibitor ☐No ☐Historical ☐Yes – Current BU: __________

Indication: ☐Prophylaxis ☐On-Demand ☐Pre-surgery or procedure ☐Other: ______________________

IV Access: ☐Peripheral ☐Port ☐PICC

Flush Protocol: ☐5cc 0.9% NaCl before and after infusion ☐Other: ______________________

Maintain line with: ☐1cc 10U/cc heparin (peripheral) ☐3cc 100u/cc heparin (PICC) ☐5cc 100U/cc heparin (port)

Nursing Care: ☐Home nursing needed ☐Nursing already coordinated - - Agency: __________ Phone: __________

☐Infused in office ☐Patient self-administers

Supplies: **AllianceRx Walgreens Prime to provide all supplies and ancillary equipment necessary for home infusion**

PRESCRIPTION INFORMATION

Factor VIII ☐Advate ☐Adynovate ☐Afstyla ☐Alphanate ☐Eloctate ☐Helixate FS ☐Hemofil M ☐Koate ☐Kogenate FS ☐Kovaltry ☐Monoclate P ☐Novoeight ☐Recombinate ☐Xyntha					
Factor IX ☐AlphaNine SD ☐Alprolix ☐Bebulin ☐Benefix ☐Idelvion ☐Ixinity ☐Mononine ☐Profilnine ☐Rixubis					
Von Willebrand Disease ☐Humate P ☐Wilate					
Factor VII and Anti-inhibitor ☐Feiba ☐NovoSeven					
Ancillary ☐Amicar ☐Cyklokapron ☐Lysteda ☐Stimate nasal spray ☐Tranexemic Acid					
☐**Other**					

I authorize, by my signature below, the dispensing of appropriate needles and syringes, in a sufficient quantity, required for the administration of injectable products by patient or caregiver. Authorization for supplies runs concurrently with the number of refills or time frame specified for the drug.

PRESCRIBER INFORMATION

Prescriber's name: ______________________ Practice/facility: ______________________

Address: ______________________ City: __________ State: ______ Zip code: __________

Office contact: ______________________ Phone: __________ Fax: __________

Email: ______________________ Best time to call: __________ Preferred method of contact: ☐Email ☐Phone ☐Fax

State license #: __________ DEA #: __________ NPI #: __________ Medicaid UPIN #: __________

In order for a brand name product to be dispensed, the prescriber must handwrite **"Brand Necessary"** or **"Brand Medically Necessary"** or your state specific required language after their signature. I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge. Prescriber's signature required on one of the lines below.

______________________ Dispense as written

______________________ Substitution permitted

______________________ Date

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

The document(s) accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

Drug names are the property of their respective owners.

©2021 AllianceRx Walgreens Prime. All rights reserved. 021521