elixir
SPECIALTY PHARMACY

Bleeding Disorder Enrollment Form

Fax: 877- 309-0687 Call: 877-437-9012

Date Fill Needed:
____/____/_____

☐ New to Therapy
☐ Current to Therapy

Customer Information

Customer Name: _____
Date of Birth: _____Gender: Male or Female
Address: _____
City: _____State:_____Zip:_____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-mail: _____

Please attach copy of front and back of customer's insurance card(s)
Insurance Company Name: _____
Insurance Company Phone: _____
Policy holder: _____
Policy holder Employer: _____
Relationship to Customer: _____
Prescription Coverage ID# _____Group# _____
RxBIN: _____RxPCN: _____
Copay Card: _____

Prescriber Information

Hemophilia Treatment Center Affiliation: _____
Patient's Coordinator Contact: _____
Practice/Organization Name: _____
Physician Name: _____
Address: _____
City: _____State: _____ Zip: _____
Phone#:_____Fax#:_____
DEA#_____NPI# _____
License#:_____Medicaid UPIN#:_____
Shipment Address:_____
Attn: _____
City: _____State: _____Zip:_____
Current Nursing Agency or indicate if nursing needs set up:_____

_____
If shipped to the physician's office, physician accepts on behalf of patient for administration in office.

Clinical Information and Prescription

Primary Diagnosis

☐D66.0 Hemophilia A (Factor VIII deficiency) ☐D67.0 Hemophilia B (Factor IX Deficiency)
☐D68.1 Hemophilia C (Factor XI Deficiency) ☐D68.0 von Willebrand disease; type ☐1 ☐2 ☐3
☐D68.2 Hereditary Deficiency (Factor X Deficiency) ☐D68.2 Hereditary Deficiency (Factor XIII Deficiency)
☐_____ Other: _____

Severity: ☐Mild (>5% Activity) ☐Moderate (1-5% activity) ☐Severe (<1% activity)
Target Joints? ☐ No ☐ Yes: _____
Inhibitor Activity: ☐None ☐Historical ☐Current: _____ B.U. Bypassing Agent Use: ☐None ☐Yes: _____
Patient Height: _____ Weight: _____ Date Taken: _____ Allergies: _____
Current Medications: _____
Co-Morbidities: _____
Vascular Access: ☐ Peripheral IV ☐Port-a-cath ☐PICC ☐Central line ☐ SQ ☐ Other: _____
Infusion by: ☐Patient ☐Caregiver ☐Nursing Agency: _____ ☐Other: _____
Most recent bleed date and outcome: _____

Factor VIII

Recombinant:	☐ Advate	☐ Hemlibra	☐ Kogenate FS	☐ Kovaltry
	☐ Novoeight	☐ Nuwiq	☐ Recombinate	☐ Xyntha
Long Acting Recombinant:	☐ Adynovate	☐ Afstyla	☐ Eloctate	
Plasma Derived:	☐ Hemofil M	☐ Koate DVI		

Write DAW here if needed

Factor IX
☐ Alprolix ☐ Alphanine SD ☐ Benefix ☐ Idelvion
☐ Ixinity ☐ Mononine ☐ Profilnine SD ☐ Rebinyn ☐ Rixubis

Anti-Inhibitor Products:
☐ Feiba VH & NF
☐ Novoseven ☐ Novoseven RT

Other:
☐ Aminocaproic acid
☐ Stimate ☐ Tranexamic acid

Factor X: To order Coagadex*, please call 844-4BPLUSA

Factor XIII:
☐ Tretten ☐ Corifact

Antithrombotic Factor / von Willebrand Factor Complex:
☐ Alphanate ☐ Humate-P ☐ Thrombate III ☐ Wilate vonWillebrand ☐ Vonvendi

Dosing Regimen	Prophylaxis	Minor bleed	Moderate Bleed	Severe Bleed
Dose in Units (mg for Factor VII)				
Number of Doses per month to dispense				

Flush Orders:
Before Factor: ☐ NaCl 0.9% (NS) ____ml ☐Heparin 10u/ml ____ml ☐Heparin 100u/ml _____ml
After Factor: ☐ NaCl 0.9% (NS) ____ml ☐Heparin 10u/ml ____ml ☐Heparin 100u/ml _____ml
Supplies requested: _____

Refills Authorized: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 6 months ☐1 year ☐ Other: _____

Physician Signature (no stamps):_____ Date: _____