

Specialty Pharmacy Enrollment Form

 Please detach before submitting to a pharmacy – tear here.

## PATIENT INFORMATION

Please complete the following or **send patient demographic sheet**

Patient Name \_\_\_\_\_  
 DOB \_\_\_\_\_ Last Four of SS# \_\_\_\_\_  
 Gender \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, State, ZIP \_\_\_\_\_  
 Home Phone \_\_\_\_\_  
 Alternate Phone \_\_\_\_\_  
 Language Preference:  English  Spanish  Other \_\_\_\_\_

## PRESCRIBER INFORMATION

Prescriber's Name \_\_\_\_\_  
 NPI \_\_\_\_\_ DEA \_\_\_\_\_  
 HTC/Group/Hospital \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, State, ZIP \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 Contact Person \_\_\_\_\_ Phone \_\_\_\_\_

## INSURANCE INFORMATION (Must fax a copy of patient's insurance card including both sides)

Prior Authorization Reference number \_\_\_\_\_

## MEDICAL INFORMATION (Section must be completed to process prescription) (Attach separate sheet if needed)

**Diagnosis** — Please include diagnosis name with ICD-10 code

D66 Hereditary factor VIII deficiency  D67 Hereditary factor IX deficiency  
 D68.1 Hereditary factor XI deficiency  
 Other Diagnosis: ICD-10 Code \_\_\_\_\_

Description \_\_\_\_\_

Date of Diagnosis \_\_\_\_\_

Start Date \_\_\_\_\_ End Date \_\_\_\_\_

Next Infusion Date \_\_\_\_\_ Target Joints:  No  Yes \_\_\_\_\_

Infusion by:  Parent  Patient  Other \_\_\_\_\_

**Protocol:**

Standard  Pre-Surgical  Continuous Prophylaxis  Immune Tolerance

**Additional Information**

Therapy:  New  Reauthorization  Restart

Weight \_\_\_\_\_ kg/lbs Height \_\_\_\_\_ cm/in

Allergies \_\_\_\_\_

Circulating Factor \_\_\_\_\_% Inhibitor:  No  Historical  Current

Historical Response:  High  Low Date \_\_\_\_\_

Concomitant Medications \_\_\_\_\_

**Factor Deficiency:**  Severe (<1%)  Moderate (1–5%)  Mild (>5%)

## PRESCRIPTION INFORMATION (If patient resides in New York, a prescription is required for needles)

### Medication

Advate®  Adynovate®  Afstyla®  Alphanate®  AlphaNine® SD  Alprolix®  Bebulin®  Benefix®  Corifact®  
 Elocate®  Feiba®  Helixate® FS  Hemlibra®  Hemofil M®  Humate P®  IDELVION®  Ixinity®  Jivi®  
 Koate®  Koate® DVI  Kogenate® FS  Kovaltry®  Monoclote® P  Mononine®  NovoEight®  NovoSeven® RT  Nuwiq®  
 Profilnine®  Recombinate®  Riastap®  Rixubis®  Tretten®  Vonvendi®  Wilate®  Xyntha®  
 Xyntha® Solofuse  Other

Heparin

EMLA

Ancillary Supplies

NaCl injections

**\*Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Ship to:  Patient  Office  Other \_\_\_\_\_ Date \_\_\_\_\_ Needs by Date \_\_\_\_\_

Product Substitution permitted  Dispense as Written

Prescriber's Signature \_\_\_\_\_ Date \_\_\_\_\_ Supervising Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Electronic or digital signatures not accepted.

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