MedRX Infusion
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Hemophilia Referral Form

Administer At: Patien's Home Prescriber's Office Other:__________ Hold shipment until notified by prescriber Anticipated Start Date: __________

1. Patient Information

Last Name:
First Name: __________
Date of Birth: __________ Phone: __________
Address: __________
City: __________ State: __________ Zip: __________

2. Prescriber Information

Prescriber Name: __________
Address: __________
City: __________ State: __________ Zip: __________
Phone: __________ Fax: __________
NPI# __________ Office Contact: __________

3. Diagnosis and Clinical Information (Please fax recent clinical notes, labs and tests, with the prescription to expedite the prior authorization)

Allergies: __________ Height: __________ Weight: __________
Tried/Failed Meds and Therapies: __________
Diagnosis (ICD 10 Code): __________

4. Prescription Information

DAW1- Dispense as written. Do not substitute for generic

Medication	Strength	Dose and Directions	Dispense	Refill
Advate, Adynovate, Afstyla, Alphanate, AlphaNine, Alprolix, BeneFIX, Coagadex, Corifact, Ceprotin, Eloctate, Esperoct, Feiba NF, Hemofil-M, Humate-P, Idelvion, Ixinity, Jivi, Koate-DVI, Kovaltry, Novoeight, Nuwiq, Obizur, Rebinyn, Recombinate, Rixubis, Thrombate III, Tretten, Vonvendi, Wilate, Xyntha	____IU/KG	Prophylaxis: __________ Breakthrough Bleed: Infuse _______units (+/- 10%) slow IV push every _______hours / days (circle one) for a total of _______doses as needed for bleeding episodes. Minor ____IU q_____hr PRN Other: __________ Major: ____IU q_____hr PRN Other: __________ Immune Tolerance: __________		
AMICAR **Generic: Aminocaproic Acid**	500MG tablet 1000mg tablet Syrup 250mg/ml	Dose: __________		
Hemlibra	Single-dose vials 30 mg/mL 60 mg/0.4 mL 05 mg/0.7 mL 150 mg/1 mL Weight: ______ kg	Initial dose: 3 mg/kg subcutaneously once weekly for 4 weeks Maintenance dose: 1.5 mg/kg subcutaneously every week 3 mg/kg subcutaneously every 2 weeks 6 mg/kg subcutaneously every 4 weeks		
NovoSeven RT *Available as* *NovoSeven RT* *1mg; 2mg; 5mg ; 8mg*	_____ mcg/kg Weight: _____kg	Infuse ______ mcg/kg slow IV push every _____hours, and/or __________		
SevenFact	1mg 5mg Round to nearest whole vial. Weight: _______kg	For Mild/Moderate bleeds: 75 mcg/kg repeat q 3 hours until hemostasis achieved or Initial dose of 225 mcg/kg. May infuse 75 mcg/kg q 3 hours prn if hemostasis not achieved within 9 hours. For Severe bleeds: 225 mcg/kg, followed if necessary 6 hours later with 75 mcg/kg every 2 hours Other: __________		
Other				

Order will include as needed: Anaphylaxis kit, Diluents, Flushes, Supplies. Skilled Home Health nursing services if administered at home

Prescriber Authorization (No stamps. Signature and date must be completed in prescriber's handwriting)

I authorize MedRX Infusion Clinical Pharmacy to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans.

Prescriber Signature PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. __________ Date __________