

Bleeding Disorder Therapy Order Form

C-2024

Patient Name: _____ DOB: _____ Phone: _____
 Address: _____ City: _____ State: _____ Zip: _____

1. Please submit with form

- Copy of insurance card ● Patient demographics ● History & physical ● Recent clinic notes
- Labs pertaining to therapy (ex. factor levels, inhibitor testing, or other documentation supporting diagnosis)

2. Patient information: Male Female Height: _____ in cm Weight: _____ lbs kg
 Allergies: _____ NKDA Line type: PIV PICC Port No. of lumens
 Is patient new to this therapy? No Yes History of inhibitor? No Yes:
 Is patient/caregiver independent with infusing factor? Yes No Nursing services needed? Yes No
 When is medication needed (upcoming procedure, active bleeding, etc.):

3. Diagnosis and Clinical Information

ICD-10 Code (required): Factor X deficiency
 Hemophilia A (Factor VIII) Mild Mod Severe Factor XIII deficiency
 Hemophilia B (Factor IX) Mild Mod Severe Glanzmann’s Thrombasthenia
 Von Willebrand, type 1 2 3 Subtype: Wiskott-Aldrich Syndrome
 Factor VII deficiency Other:

4. Prescription Information

Factor Replacement Therapy (Dose dispensed may be +/-10% unless otherwise specified)	
Prophylaxis	Product: _____ Dose: _____ units VWF:RCo Give IV once every _____ days week(s) Other: _____ Dispense: 1 month supply / Refill x _____ 6 months 1 year Other:
On-Demand (PRN bleeding, procedure, or as directed)	Product: _____ Dose: _____ units VWF:RCo Give IV once every _____ hours days as needed for bleed, procedure, or as directed. Other: _____ Dispense: total doses (OR: minor doses, major doses) / Refill x _____ Patient to keep doses in stock / Keep at least 3 day supply in home
<input type="checkbox"/> Other	Product: _____ Dose: _____ units VWF:RCo for IV administration Frequency / directions: _____ Dispense: _____ doses / Refill x _____ Other:
Administration	<input checked="" type="checkbox"/> RN (or caregiver/patient if independent) to start peripheral IV or use existing CVC <input checked="" type="checkbox"/> Flush IV catheter with NS & heparin, if indicated, per PromptCare policy and procedure Other:

Hemlibra (Emicizumab) Therapy	
Loading Doses	3 mg/kg once weekly for 4 weeks Other: _____ Dosing weight: _____ kg Begin maintenance dose _____ weeks after final loading dose Dispense: Quantity sufficient to complete loading dose regimen OR _____ doses/No refills
Maintenance Dose	1.5 mg/kg weekly 3 mg/kg every 2 weeks 6 mg/kg every 4 weeks Other: _____ Dosing weight: _____ kg Dispense 1 month supply / Refill x _____

Confidential Health Information: Healthcare information is personal information related to a person’s healthcare. It is being faxed to you after appropriate authorization and under circumstances that don’t require authorization. You are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure of this information is prohibited by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law. Important Warning: This message is intended for the use of the person or entity to who it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any discrimination, distribution, or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately.

Oral Medications	
Medication	Aminocaproic acid 0.25 g/mL oral solution Aminocaproic acid tablets (500 mg or 1000 mg tablets) Tranexamic acid 650 mg tablets
Directions	Give _____ mg mg/kg mL by mouth every _____ hours as needed for bleeding, procedure, or as directed. Other:
Quantity	Dispense: _____ tablets OR _____ mL OR: _____ / Refill x

Desmopressin (DDAVP)	
Subcutaneous injection (desmopressin 4 mcg/mL)	Give _____ mcg mcg/kg mL subcutaneously, frequency: Give one dose 30 to 60 minutes prior to procedure Other: Dispense _____ dose(s) / Refill x
Nasal spray (desmopressin 1.5 mg/mL)	<input checked="" type="checkbox"/> Dose based on patient weight as follows: <ul style="list-style-type: none"> Weight <50 kg: administer 150 mcg (1 spray) in a single nostril Weight ≥50 kg: administer 150 mcg (1 spray) in each nostril (total dose 300 mcg) Directions: Give one dose as needed for bleeding, may repeat after 8-12 hours then daily up to a maximum of 3 days Give one dose 2 hours prior to procedure Other: Dispense 1 bottle / Refill x

Dispense all medical supplies necessary for administration of prescribed medications

Provide skilled nursing to administer/teach preparation and infusion of prescribed medications

Other:

5. Adverse Reaction Orders (if applicable):

6. Prescriber Information

Prescriber Name:

Address:

Phone:

License #:

Office Contact:

City:

Fax:

State:

Zip:

DEA #:

NPI:

Physician Signature (Substitution Permitted)

Date

Physician Signature (Dispense as Written)

Date

By signing I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment. PromptCare has my permission to contact the patient's health plan to obtain any authorizations necessary to enable it to receive payment for services.