promptcare

Intake Specialist: 1-866-776-6782
Fax: 800-815-6808
newreferral@promptcare.com

C-2024

Bleeding Disorder Therapy Order Form

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): _____

☐Hemophilia A (Factor VIII) ☐Mild ☐Mod ☐Severe
☐Hemophilia B (Factor IX) ☐Mild ☐Mod ☐Severe
☐Von Willebrand, type ☐1 ☐2 ☐3 Subtype: _____
☐Factor VII deficiency
☐Factor X deficiency
☐Factor XIII deficiency
☐Glanzmann's Thrombasthenia
☐Wiskott-Aldrich Syndrome
☐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
☐ **Other**	Product: _____ Dose: _____ ☐units ☐VWF:RCo for IV administration Frequency / directions: _____ Dispense: _____ doses / Refill x _____ Other: _____
Administration	☒RN (or caregiver/patient if independent) to start peripheral IV or use existing CVC ☒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 _____

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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)	☒ Dose based on patient weight as follows: • 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: _____ Office Contact: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
License #: _____ 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.