benevere PHARMACY

60 Market Center Dr. #103, Collierville, TN 38017
O: 901.316.5752 TP: 855.344.8724 F: 901.316.5760 TF: 844.588.5560
beneverepharmacy.com

TODAY'S DATE: _____

☐ NEW PATIENT ☐ CURRENT PATIENT

Hemophilia Referral Form

PATIENT INFORMATION

Patient Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____

DOB _____ SSN _____

Drug Allergies _____ ☐ Male ☐ Female

Patient Weight: _____ Height: _____

PRESCRIBER INFORMATION

Prescriber Name _____ DEA# _____

NPI# _____ Tax ID _____

Practice Name _____

Address _____ Suite _____

City _____ State _____ Zip _____

Office Phone _____ Fax _____

Office Contact _____

INSURANCE, MEDICARE OR MEDICAID INFORMATION

Primary Insurance _____

Policy # _____ Group _____

Insurance Phone _____

Prescription Drug Coverage: Company _____

RXGRP# _____ RXBIN# _____ PCN/ID# *(if available)* _____

Secondary Insurance (if applicable) _____

Policy # _____ Group _____

Insurance Phone _____

Phone _____

COMPLETE OR FAX FRONT AND BACK COPIES OF INSURANCE AND PRESCRIPTION BENEFIT CARDS IF AVAILABLE

CLINICAL INFORMATION

Diagnosis: ☐ D66 Hemophilia A ☐ D67 Hemophilia B ☐ D68.1 Hemophilia C ☐ D68 von Willebrands ☐ Other ICD-10 _____ Date Diagnosed: _____

FVIII/FIX assay: _____ U/ml FVIII/FIX activity: _____ % Inhibitor Titer: _____ BU/ml Date: _____

New to therapy: ☐ Yes ☐ No If no, date therapy began: _____ Method of Administration: ☐ PIC ☐ Port ☐ IV Catheter

PLEASE ATTACH A LIST OF PATIENTS'S CURRENT MEDICATIONS.

MEDICATIONS

☐ Advate	☐ Helixate	☐ NovoSeven RT	☐ 0.9% sodium chloride 5-10mL pre/post infusion and PRN
☐ AlphaNine	☐ Hemofil M	☐ Profilnine	☐ Heparin 10 Units/mL 5mL post infusion and PRN
☐ Alphanate	☐ Humate-P	☐ Recombinate	☐ Heparin 100 Units/mL 5mL post infusion and PRN
☐ Bebulin	☐ Koate DVI	☐ RIXUBIS	☐ Standard supplies for administration as requested
☐ Benefix	☐ Kogenate FS	☐ Stimate	☐ Sharps container
☐ Corifact	☐ Monoclate-P	☐ Wilate	☐ Other _____
☐ FEIBA	☐ Mononine	☐ Xyntha	_____
			_____

PRESCRIPTION INFORMATION

Prophylactic Dosing: Dose: _____ Frequency: _____ Refills: _____ Goal: _____

☐ Dispense 30 day supply based on frequency ☐ Dispense _____ doses for a 30 day supply

Episodic Dosing: Bleeding Dose: _____

Dispense _____ doses for a 30 day supply Refills _____

Infusion to be given by: ☐ Patient ☐ Parent ☐ Other _____

☐ Patient/caregiver has received infusion training ☐ Physician's office to provide infusion training ☐ Benevere Rx to coordinate infusion training

Deliver to: ☐ Patient's home ☐ MD's Office ☐ 1st dose to MD's Office, remaining refills to patient's home

By signing this form and utilizing our services, you are authorizing Benevere and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) _____ Date _____