benevere PHARMACY

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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# ____________

Secondary Insurance (if applicable) ____________
Policy # ____________ Group ____________
Insurance Phone ____________
Phone ____________
PCN/ID# *(if available)* ____________

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

Factor VIII				**Factor IX**		**Miscellaneous**
☐ Advate	☐ FEIBA	☐ Jivi	☐ NovoEight	☐ AlphaNine	☐ Profilnine	☐ Amicar
☐ Adynovate	☐ Helixate	☐ Koate DVI	☐ Nuwiq	☐ Aprolix	☐ Rebinyn	☐ Corifact
☐ Afstyla	☐ Hemlibra	☐ Kogenate-FS	☐ Obizur	☐ Bebulin	☐ Rixubis	☐ NovoSeven RT
☐ Alphanate	☐ Hemofil M	☐ Kovaltry	☐ Recombinate	☐ Benefix		☐ Stimate
☐ Autoplex	☐ Humate-P	☐ Monarc	☐ Xyntha	☐ Ixinity		☐ Tranexemic Acid
☐ Eloctate	☐ Hyate	☐ Monoclate-P		☐ Mononine		☐ Wilate

☐ 0.9% sodium chloride 5-10mL pre/post infusion and PRN ☐ Heparin 10 Units/mL 5mL post infusion and PRN ☐ Heparin 100 Units/mL 5mL post infusion and PRN
☐ Standard supplies for administration as requested ☐ Sharps container ☐ Other ____________

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 ____________

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