elixir SPECIALTY PHARMACY

Bleeding Disorder Enrollment Form
Fax: 877- 309-0687 Call: 877-437-9012

Date Fill Needed: ____/____/______

☐ New to Therapy
☐ Current to Therapy

Customer Information

Customer Name: ______________________
Date of Birth: ______________________ Gender: Male or Female
Address: ______________________
City: ____________ State: ____________ Zip: ____________
Home Phone: ____________ Work Phone: ____________
Cell Phone: ____________ E-mail: ____________

Please attach copy of front and back of customer's insurance card(s)
Insurance Company Name: ______________________
Insurance Company Phone: ______________________
Policy holder: ______________________
Policy holder Employer: ______________________
Relationship to Customer: ______________________
Prescription Coverage ID# ____________ Group# ____________
RxBIN: ____________ RxPCN: __ ____________
Copay Card: ______________________

Prescriber Information

Hemophilia Treatment Center Affiliation: ______________________
Patient's Coordinator Contact: ______________________
Practice/Organization Name: ______________________
Physician Name: ______________________
Address: ______________________
City: ____________ State: ____________ Zip: ____________
Phone#: ____________ Fax#: ____________
DEA# ____________ NPI# ____________
License#: ____________ Medicaid UPIN#: ____________
Shipment Address: ______________________
Attn: ______________________
City: ____________ State: ____________ Zip: ____________
Current Nursing Agency or indicate if nursing needs set up: ____________
____

If shipped to the physician's office, physician accepts on behalf of patient for administration in office.

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Clinical Information and Prescription

Primary Diagnosis
☐D66.0 Hemophilia A (Factor VIII deficiency) ☐D67.0 Hemophilia B (Factor IX Deficiency)
☐D68.1 Hemophilia C (Factor XI Deficiency) ☐D68.0 von Willebrand disease; type ☐1 ☐2 ☐3
☐D68.2 Hereditary Deficiency (Factor X Deficiency) ☐D68.2 Hereditary Deficiency (Factor XIII Deficiency)
☐______ Other: ______________________

Severity: ☐Mild (>5% Activity) ☐Moderate (1-5% activity) ☐Severe (<1% activity)
Target Joints? ☐ No ☐ Yes: ______________________
Inhibitor Activity: ☐None ☐Historical ☐Current: __________ B.U. **Bypassing Agent Use:** ☐None ☐Yes: __________
Patient Height: ________ Weight: ________ Date Taken: ______ Allergies: ____________
Current Medications: ______________________
Co-Morbidities: ______________________
Vascular Access: ☐ Peripheral IV ☐Port-a-cath ☐PICC ☐Central line ☐ SQ ☐ Other: __________
Infusion by: ☐Patient ☐Caregiver ☐Nursing Agency: __________ ☐Other: __________
Most recent bleed date and outcome: ______________________

Factor VIII
Recombinant: ☐ Advate ☐ Hemlibra ☐ Kogenate FS ☐ Kovaltry ☐ Novoeight ☐ Nuwiq ☐ Recombinate ☐ Xyntha
Long Acting Recombinant: ☐ Adynovate ☐ Afstyla ☐ Eloctate
Plasma Derived: ☐ Hemofil M ☐ Koate DVI

Write DAW here if needed

Factor IX
☐ Alprolix ☐ Alphanine SD ☐ Benefix ☐ Idelvion
☐ Ixinity ☐ Mononine ☐ Profilnine SD ☐ Rebinyn ☐ Rixubis

Anti-Inhibitor Products:
☐ Feiba VH & NF
☐ Novoseven ☐ Novoseven RT

Other:
☐ Aminocaproic acid
☐ Stimate ☐ Tranexamic acid

Factor X: To order Coagadex*, please call 844-4BPLUSA

Factor XIII:
☐ Tretten ☐ Corifact

Antithrombotic Factor / von Willebrand Factor Complex:
☐ Alphanate ☐ Humate-P ☐ Thrombate III ☐ Wilate vonWillebrand ☐ Vonvendi

Dosing Regimen	Prophylaxis	Minor bleed	Moderate Bleed	Severe Bleed
Dose in Units (mg for Factor VII)				
Number of Doses per month to dispense				

Flush Orders:
Before Factor: ☐ NaCl 0.9% (NS) ____ml ☐Heparin 10u/ml ____ml ☐Heparin 100u/ml ______ml
After Factor: ☐ NaCl 0.9% (NS) ____ml ☐Heparin 10u/ml ____ml ☐Heparin 100u/ml ______ml
Supplies requested: ______________________
Refills Authorized: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 6 months ☐1 year ☐ Other: __________

Physician Signature (no stamps): ______________________ **Date:** __________