



Treatment Setting	Home by: <input type="checkbox"/> Patient/caregiver <input type="checkbox"/> Walgreens nurse <input type="checkbox"/> Other: _____		Referral date: _____	
	<input type="checkbox"/> MD office <input type="checkbox"/> Walgreens treatment site <input type="checkbox"/> Other: _____		Need by date/time: _____	
Patient Information Please type or print clearly. (OR fax demographic sheet)	Name: _____			
	DOB: _____		Gender: _____	Language: _____
	Address: _____			
	City: _____		State: _____	ZIP: _____
	Home phone w/area code: _____		Alternate phone w/area code: _____	
	Caregiver name(s): _____		Caregiver relationship: _____	
	Emergency contact name: _____		Phone: _____	
Medical Insurance Information Please attach a copy of card if possible. (OR fax front and back of medical and prescription cards)	Primary insurance: _____	Cardholder name/DOB: _____	Cardholder employer: _____	
	ID#: _____	Group#: _____	Phone: _____	
	Secondary insurance: _____	Cardholder name/DOB: _____	Cardholder employer: _____	
	ID#: _____	Group#: _____	Phone: _____	
	Prescription card: _____		Phone: _____	
	ID#: _____	Group#: _____	BIN#: _____	PCN#: _____
Prescriber Information (Unless on faxed Rx)	Name: _____			
	Address: _____		City: _____	State: _____
	Phone w/area code: _____		Fax w/area code: _____	
	NPI: _____	LIC: _____	Supervising name if CPNP or PA: _____	
Medical History	<input type="checkbox"/> 286.0- Congenital factor VIII disorder (Hemophilia A)	<input type="checkbox"/> 286.1- Congenital factor IX disorder (Hemophilia B)		
	<input type="checkbox"/> 286.2- Congenital factor XI deficiency (Hemophilia C)	<input type="checkbox"/> 286.3- Deficiency of other clotting factors (Circle: I, II, V, VII, X, XII, XIII)		
	<input type="checkbox"/> 286.4- von Willebrand disease (Circle type: 1, 2A, 2B, 2M, 2N, 3)	<input type="checkbox"/> 286.7- Acquired coagulation factor deficiency		
	<input type="checkbox"/> 286.9- Unspecified coagulation defects	Other- Please indicate ICD9-CM code(s): _____		
	Description: _____			
	Baseline factor percent: _____	Target joint(s) <input type="checkbox"/> No <input type="checkbox"/> Yes _____	Inhibitor: <input type="checkbox"/> No <input type="checkbox"/> History <input type="checkbox"/> Current _____	BU/mL
	Inhibitor protocol: _____			
	DNR/Advance directive status: <input type="checkbox"/> Received <input type="checkbox"/> N/A Hep B, Hep C, HIV or TB positive? (circle) Date chest x-ray _____			
	Drug allergies: _____ Other conditions/other meds: _____			
	Vascular access: <input type="checkbox"/> Peripheral <input type="checkbox"/> Port <input type="checkbox"/> Other _____	Weight: _____	<input type="checkbox"/> kg <input type="checkbox"/> lbs	Height: _____
Prescriptions (OR fax separately)	<input type="checkbox"/> EpiPen Adult (0.3 mg) as directed for reactions, qty:1 <input type="checkbox"/> EpiPen Jr (0.15 mg) as directed for reactions, qty:1			
	Factor VIII recombinant: <input type="checkbox"/> Advate <input type="checkbox"/> Helixate FS <input type="checkbox"/> Kogenate FS <input type="checkbox"/> Recombinate <input type="checkbox"/> Xyntha <input type="checkbox"/> Other _____			
	Plasma derived: <input type="checkbox"/> Hemofil M <input type="checkbox"/> Monoclate-P <input type="checkbox"/> Other _____			
	Approximate units and directions: _____ Dispense qty: _____ Refills: _____			
	Factor VIII and von Willebrand plasma derived: <input type="checkbox"/> Alphanate <input type="checkbox"/> Humate-P <input type="checkbox"/> Koate-DVI <input type="checkbox"/> Wilate <input type="checkbox"/> Other _____			
	Approximate units <input type="checkbox"/> VWF <input type="checkbox"/> Factor VIII and directions: _____ Dispense qty: _____ Refills: _____			
	Factor IX recombinant: <input type="checkbox"/> BeneFix <input type="checkbox"/> Other _____			
	Plasma derived: <input type="checkbox"/> AlphaNine SD <input type="checkbox"/> Mononine <input type="checkbox"/> Other _____			
	Approximate units and directions: _____ Dispense qty: _____ Refills: _____			
	Factor VII recombinant: <input type="checkbox"/> NovoSeven RT <input type="checkbox"/> Other _____			
	Dose (mg) and directions: _____ Dispense qty: _____ Refills: _____			
	Activated Prothrombin Complex Concentrates plasma derived: <input type="checkbox"/> Feiba VH <input type="checkbox"/> Other _____			
	Approximate units and directions: _____ Dispense qty: _____ Refills: _____			
	Prothrombin Complex Concentrates plasma derived: <input type="checkbox"/> Bebulin VH <input type="checkbox"/> Profilnine SD <input type="checkbox"/> Other _____			
	Approximate units and directions: _____ Dispense qty: _____ Refills: _____			
Stimate 1 spray in <input type="checkbox"/> one nostril <input type="checkbox"/> each nostril _____ Dispense qty: _____ Refills: _____				
Amicar <input type="checkbox"/> syrup <input type="checkbox"/> 500/1000 mg tab Dose and directions: _____ Dispense qty: _____ Refills: _____				
Other (continuous infusion, Rituxan, vancomycin, etc) _____				
Line care: <input type="checkbox"/> Sodium chloride 0.9% 5-10ml <input type="checkbox"/> 3-5 ml Heparin (<input type="checkbox"/> 10 units/mL <input type="checkbox"/> 100 units/mL) <input type="checkbox"/> Other: _____				
<input type="checkbox"/> Apply 30-60 minutes prior to access (<input type="checkbox"/> Emla 30 gram <input type="checkbox"/> LMX 30 gram) <input type="checkbox"/> Other: _____				
Nursing orders: <input type="checkbox"/> Skilled nurse to infuse/teach mixing, infusion, self-monitoring, other aspects of care _____				
Lab orders: _____				
Supplies: <input type="checkbox"/> All infusion and prevention supplies as needed and/or _____				
Prescriber Certification	I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.			
	Prescriber's signature required: _____			Date: _____

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