

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, 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): _____ Factor X deficiency
 Hemophilia A (Factor VIII) Mild Mod Severe* Factor XIII deficiency
 Hemophilia B (Factor IX) Mild Mod Severe* Glanzmann's Thrombasthenia
 Von Willebrand, type 1 2 3 _____* Wiskott-Aldrich Syndrome
 Factor VII deficiency Other: _____

4. Prescription Information

Factor Replacement Therapy	
<input type="checkbox"/> Prophylaxis	Product: _____ Dose: _____ <input type="checkbox"/> units <input type="checkbox"/> VWF:RCo Give IV once every ____ <input type="checkbox"/> days <input type="checkbox"/> week(s) <input type="checkbox"/> Other: _____ Dispense: 1 month supply / Refill x <input type="checkbox"/> 6 months <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> On-Demand (PRN bleeding, procedure, or as directed)	Product: _____ Dose: _____ <input type="checkbox"/> units <input type="checkbox"/> VWF:RCo Give IV once every _____ <input type="checkbox"/> hours <input type="checkbox"/> days PRN bleed, procedure, or as directed Other: _____ Dispense: ____ total doses (OR: ____ minor doses, ____ major doses) / Refill x _____ <i>Optional:</i> Patient to keep ____ doses in stock / <input type="checkbox"/> Keep at least 3 day supply in home
<input type="checkbox"/> Other	Product: _____ Dose: _____ <input type="checkbox"/> units <input type="checkbox"/> VWF:RCo IV Frequency / directions: _____ Dispense: _____ doses / Refill x _____ Other: _____
Administration	<input checked="" type="checkbox"/> RN (or caregiver/patient if independent) to start peripheral IV or use existing CVC <input checked="" type="checkbox"/> Flush IV catheter with NS & heparin, if indicated, per PromptCare policy and procedure <input type="checkbox"/> Other: _____

Hemlibra (Emicizumab) Therapy	
<input type="checkbox"/> Loading Doses	<input type="checkbox"/> 3 mg/kg once weekly for 4 weeks <input type="checkbox"/> Other: _____ Dosing weight: _____ kg Begin maintenance dose ____ weeks after final loading dose Dispense: Quantity sufficient to complete loading dose regiment OR ____ doses/No refills
<input type="checkbox"/> Maintenance Dose	<input type="checkbox"/> 1.5 mg/kg weekly <input type="checkbox"/> 3 mg/kg every 2 weeks <input type="checkbox"/> 6 mg/kg every 4 weeks <input type="checkbox"/> Other: _____ Dosing weight: _____ kg Dispense 1 month supply / Refill x _____

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Oral Medications	
Medication	<input type="checkbox"/> Aminocaproic acid 0.25 g/mL oral solution <input type="checkbox"/> Aminocaproic acid tablets (<input type="checkbox"/> 500 mg or <input type="checkbox"/> 1000 mg tablets) <input type="checkbox"/> Tranexamic acid 650 mg tablets
Directions	Give _____ <input type="checkbox"/> mg <input type="checkbox"/> mg/kg <input type="checkbox"/> mL by mouth every _____ hours as needed for bleeding, procedure, or as directed. Other: _____
Quantity	Dispense: _____ tablets OR _____ <input type="checkbox"/> mL OR: _____ / Refill x _____

Desmopressin (DDAVP)	
<input type="checkbox"/> Subcutaneous injection (desmopressin 4 mcg/mL)	Give _____ <input type="checkbox"/> mcg <input type="checkbox"/> mcg/kg <input type="checkbox"/> mL subcutaneously, frequency: <input type="checkbox"/> Give one dose 30 to 60 minutes prior to procedure <input type="checkbox"/> Other: _____ Dispense _____ dose(s) / Refill x _____
<input type="checkbox"/> Nasal spray (desmopressin 1.5 mg/mL)	<input checked="" type="checkbox"/> Dose based on patient weight as follows: <ul style="list-style-type: none"> • 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: <input type="checkbox"/> Give one dose as needed for bleeding, may repeat after 8-12 hours then daily up to a maximum of 3 days <input type="checkbox"/> Give one dose 2 hours prior to procedure <input type="checkbox"/> 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

5. **Adverse Reaction Orders** (if applicable): _____

6. **Prescriber Information**

Prescriber Name: _____ Office Contact: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____
 License NO.: _____ DEA NO.: _____ NPI: _____

Physician Signature (Substitution Permitted)

 Date

Physician Signature (Dispense as Written)

 Date