promptcare

**Intake Specialist:** 1-866-776-6782
**Fax:** 800-815-6808
**newreferral@promptcare.com**

# 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):** _____

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

**4. Prescription Information**

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

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

promptcare

**Intake Specialist:** 1-866-776-6782
**Fax:** 800-815-6808
**newreferral@promptcare.com**

| **Oral Medications** | |
|---|---|
| **Medication** | ☐ Aminocaproic acid 0.25 g/mL oral **solution**<br>☐ Aminocaproic acid **tablets** (☐500 mg or ☐1000 mg tablets)<br>☐ Tranexamic acid 650 mg tablets |
| **Directions** | Give _____ ☐mg ☐mg/kg ☐mL by mouth every _____ hours as needed for bleeding, procedure, or as directed. Other: _____ |
| **Quantity** | Dispense: _____ **tablets** OR _____ ☐**mL** OR:_____ / Refill x_____ |

| **Desmopressin (DDAVP)** | |
|---|---|
| ☐ **Subcutaneous injection** (desmopressin 4 mcg/mL) | Give _____ ☐mcg ☐mcg/kg ☐mL subcutaneously, frequency:<br>☐ Give one dose 30 to 60 minutes prior to procedure<br>☐ Other: _____<br>Dispense _____dose(s) / Refill x _____ |
| ☐ **Nasal spray** (desmopressin 1.5 mg/mL) | ☒ Dose based on patient weight as follows:<br>• Weight <50 kg: administer 150 mcg (1 spray) in a **single** nostril<br>• Weight ≥50 kg: administer 150 mcg (1 spray) in **each** nostril (total dose 300 mcg)<br>Directions:<br>☐ Give one dose as needed for bleeding, may repeat after 8-12 hours then daily up to a maximum of 3 days<br>☐ Give one dose 2 hours prior to procedure<br>☐ Other: _____<br>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