

Physician Prescription Request Form for Hemophilia Drugs

Fax to PerformRx Pharmacy Services at **866-227-5764**, or to speak to a representative call **800-558-1655**. *Form must be completed for processing*

Patient Name: _____ Member ID#: _____
 Address: _____ Apt # or Suite #: _____
 City: _____ State: _____ Zip Code: _____
 Phone #: _____ Height: _____ Weight: _____ lbs = _____ Kg Birth Date: _____

Physician Name: _____ License #: _____
 Address: _____ Apt # or Suite #: _____
 City: _____ State: _____ Zip Code: _____
 Contact Person: _____ Phone #: _____ Fax #: _____
 Physician Signature: _____ E Mail: _____

Home Health Company Name: _____ Phone #: _____
 Home Health Company Address: _____ Fax #: _____
 _____ E Mail: _____
 Contact Person: _____

Factor VII

Novoseven # _____ 1200 µg vials # _____ 2400 µg vials # _____ 4800 µg vials Inhibitor Antibody Titer _____ BU

Factor VIII

Recombinate Refacto Monoclate-P Autoplex T [Anti-Inhibitor Coagulant Complex]
 Kogenate FS Other _____

_____ 100 ± IU vials # _____ 250 ± IU vials # _____ 300 ± IU vials # _____ 500 ± IU vials # _____ 600 ± IU vials # _____ 1000 ± IU vials # _____ 1600 ± IU vials # _____ 3200 ± IU vials

Factor IX

Benefix Mononine
 Other _____
 # _____ 250 ± IU vials # _____ 500 ± IU vials # _____ 1000 ± IU vials

von Willebrand

Stimate Nasal Spray 1.5 mg/mL 2.5mL Spray 00053-2453-00 26201
 Humate-P
 Other _____
 # _____ 250 ± IU vials # _____ 500 ± IU vials # _____ 1000 ± IU vials

Total Amount of Factor Requested _____ IU / µg Representing # Treatments or Doses _____

Total Amount of Factor At Home _____ iu/ug Representing # Treatments or Doses _____

For Prophylaxis or Episode Please Indicate Weekly Dose Schedule:

Sun: _____ IU/µg Mon: _____ IU/µg Tue: _____ IU/µg Wed: _____ IU/µg Thu: _____ IU/µg Fri: _____ IU/µg Sat: _____ IU/µg

Authorizations are for a maximum of 1 month duration

To Be Administered From (date) _____ to (date) _____

Diagnosis:

Hemophilia A [Factor VIII Disease] Hemophilia B [Factor IX Disease] von Willebrand Disease

Reason for Use:

Prophylaxis Episode Site: _____ Dental Extraction Surgical Procedure Other: _____
 _____ Hemorrhage (Mild)
 _____ Hemorrhage (Moderate)
 _____ Hemorrhage (Severe)