



Hemophilia & Bleeding Disorder Referral Form

Home Infusion Prescription & Referral

Patients / caregivers: complete sections 1–2 and give this form to your prescriber. Prescribers: complete sections 3–7, sign, and fax with attachments to 855-872-5872.

Referral type: ☐ New referral ☐ Renewal / re-order ☐ Dose or frequency change ☐ Discontinue therapy Needed by

Administer at: ☐ Patient's home ☐ Prescriber's office ☐ Infusion suite ☐ SNF / other ☐ Hold until notified Start date

1 PATIENT INFORMATION

Last name First name MI Date of birth Sex: ☐ M ☐ F
Street address City State ZIP
Primary phone Alternate phone Email Preferred language
Caregiver / emergency contact Relationship Phone OK to leave voicemail? ☐ Yes ☐ No

2 INSURANCE & BILLING INFORMATION

Attach copies of ALL insurance cards, front and back

Primary insurance Member ID Group # Plan phone
Subscriber name Subscriber DOB Relationship to patient Medicare ID (MBI) Medi-Cal CIN
Secondary insurance Member ID Group # Plan phone
Rx card (if separate) Rx ID RxBIN RxPCN RxGroup Coverage: ☐ Medicare ☐ Medi-Cal ☐ Commercial / PPO ☐ HMO / IPA
Prior authorization: ☐ Not started — Biologic to obtain ☐ Pending ☐ Obtained Auth # Valid dates IPA / case manager

3 PRESCRIBER & REFERRAL SOURCE

Prescriber name Credentials NPI State license #
Practice / group Phone Fax
Address City State ZIP
Office contact Direct phone / ext Contact email Supervising MD (if NP/PA)
Referral source (if different) Hospital / facility Discharge planner / case manager Phone Discharge date

4 DIAGNOSIS & CLINICAL INFORMATION

Check all that apply — codes below are common indications, not a substitute for the chart

Primary dx ICD-10 Description Secondary dx ICD-10 Description
☐ D66 Hemophilia A (factor VIII deficiency) ☐ D68.02- Von Willebrand disease, type 2 ☐ D68.311 Acquired hemophilia
☐ D67 Hemophilia B (factor IX deficiency) ☐ D68.03 Von Willebrand disease, type 3 ☐ D68.318 Hemorrhagic disorder due to inhibitors
☐ D68.00 Von Willebrand disease, unspecified ☐ D68.1 Factor XI deficiency (hemophilia C) ☐ D68.4 Acquired coagulation factor deficiency
☐ D68.01 Von Willebrand disease, type 1 ☐ D68.2 Other hereditary factor deficiency ☐ M36.2 Hemophilic arthropathy
Height in Weight lb / kg Date ☐ NKDA Allergies & reactions
Vascular access: ☐ None — needs placement ☐ Peripheral ☐ Midline ☐ PICC ☐ Port ☐ Tunneled CVC Lumens Date placed
Severity: ☐ Severe (< 1%) ☐ Moderate (1–5%) ☐ Mild (> 5%) Baseline factor activity % Date VWD type
Inhibitor: ☐ None ☐ History ☐ Current Titer BU Date Target joints
HTC / hematologist HTC phone Bleeds, last 12 mo Last bleed **Currently on prophylaxis?** ☐ Yes ☐ No
Please attach: ☐ Face sheet ☐ Insurance cards (front & back) ☐ H&P / progress notes ☐ Medication list ☐ Factor activity / inhibitor labs
☐ Treatment plan / bleed log ☐ Peri-procedure plan (if applicable)

Patient name DOB Prescriber

5 PRESCRIPTION — FACTOR / BLEEDING DISORDER THERAPY

Check product(s) ordered; dosing weight from page 1 unless noted

Factor VIII: ☐ Advate ☐ Kovaltry ☐ Novoeight ☐ Nuwiq ☐ Xyntha ☐ Recombinate ☐ Hemofil M ☐ Koate

FVIII EHL: ☐ Adynovate ☐ Elocate ☐ Esperoct ☐ Jivi ☐ Afstylia ☐ Altuviiio

VWF: ☐ Humate-P ☐ Alphanate ☐ Wilate ☐ Vonvendi

Factor IX: ☐ BeneFIX ☐ Rixubis ☐ Ixinity ☐ AlphaNine SD ☐ Alprolix ☐ Idelvion ☐ Rebinyn

Bypassing / other: ☐ NovoSeven RT ☐ Sevenfact ☐ FEIBA ☐ Obizur ☐ Corifact ☐ Tretten ☐ Coagadex ☐ Profilnine

Non-factor (SC): ☐ Hemlibra (emicizumab) ☐ Alhemo (concizumab) ☐ Hympavzi (marstacimab) ☐ Qfitlia (fitusiran)

Other product / specify Dosing weight kg Date

Regimen

☐ Prophylaxis: units/kg = units IV every day(s) or × / week Target trough %

☐ On-demand / bleed treatment: Minor bleed units/kg Major bleed units/kg repeat every h until resolved; call HTC after doses

☐ Non-factor SC therapy: Loading mg/kg weekly × wks, then mg/kg or mg SC every ☐ wk ☐ 2 wk ☐ 4 wk

☐ Immune tolerance induction (protocol attached) ☐ Peri-procedure orders attached ☐ Tranexamic acid ☐ Aminocaproic acid ☐ DDAVP

Dispense: doses on hand for bleed treatment day supply for prophylaxis ☐ OK to dispense within ± 10% of ordered units per available vial assay

6 NURSING, SUPPLIES & MONITORING

Infusion by: ☐ Patient / caregiver (already trained) ☐ RN to teach self-infusion ☐ RN to administer each dose ☐ RN visit for bleeds PRN

Supplies: ☐ Butterfly / infusion sets ☐ Huber needles size ☐ Sharps container ☐ Bleed log ☐ Flushes per protocol

Labs: ☐ Factor activity (trough / recovery) every ☐ Inhibitor screen (Bethesda) every months ☐ CBC Other

Emergency plan — nearest ER HTC on-call phone ☐ Provide ER / travel letter Other instructions

Standing orders included with every referral unless declined: anaphylaxis kit per Biologic protocol, sharps container, infusion supplies, ancillary refills × 12 months. Factor is shipped in the quantity needed to cover the regimen and the bleed-treatment doses ordered above; Biologic will confirm shipment with the patient before each delivery.

☐ Decline / modify standing orders:

7 PRESCRIBER AUTHORIZATION

Original signature required — no stamps

I certify that the factor replacement / bleeding disorder therapy ordered above is medically necessary, that the patient is under my care, and that I will supervise the patient's treatment. Unless otherwise indicated, orders are valid for 12 months from the date signed. I authorize Biologic Infusion Pharmacy to act as my agent and on behalf of my patient to initiate and complete prior authorization, appeals, and related processes with the patient's health plan(s), including submission of any required forms and clinical documentation. Biologic may release medical information to the patient's health plan(s) and to the home health agency as needed to coordinate care. This authorization may be revoked in writing at any time.

Product selection: ☐ Substitution permitted — Biologic may select product per payer formulary / availability ☐ Dispense as written

Refills x 12 months unless otherwise noted Verbal order taken by / date (pharmacy use)

Prescriber signature (no stamps)
Print name & credentials Date

CONFIDENTIALITY NOTICE: This document contains protected health information (PHI) that is legally privileged. It is intended only for the use of the recipient named above. If you are not the intended recipient, you are hereby notified that any review, disclosure, copying, distribution, or action taken in reliance on the contents of this document is strictly prohibited. If you have received this document in error, please notify Biologic Infusion Pharmacy immediately at 855-855-3221 and destroy all copies. Brand names are the property of their respective owners.