

**PATIENT INFORMATION**

Last Name	First Name	MI	ID Number
Home Address	City	State	Zip
Parent or Guardian Name			Home Phone Number ( ) ( )
Shipping Address( if different from home address)		<input type="checkbox"/> Ship to MD	Work Phone Number ( ) ( )

**INSURANCE INFORMATION** (fill out entirely or fax a copy of patient's Insurance card, both sides)

Primary Insurance	Secondary Insurance
Insured	Insured
Policy Number	Policy Number
Group Number	Group Number

**PRIMARY DIAGNOSIS**

ICD9	Diagnosis		Diagnosis
286.0	Hemophilia A (Factor VIII Deficiency)	287.1	Thrombasthenia
286.1	Hemophilia B (Factor IX Deficiency)	286.4	von Willebrand Disease Type <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
286.2	Hemophilia C (Factor XI Deficiency)	286.5	Hemorrhagic Disorders
286.3	Other Clotting Disorder	286.7	Acquired Coagulation
	Other specify _____	286.9	Other Coagulation

**MEDICAL INFORMATION**

Start Date \_\_\_\_\_ End Date \_\_\_\_\_ Infusion done by  Parent  Patient  Other \_\_\_\_\_

Factor Deficiency  Severe (<1% Activity)  Moderate (1-5% Activity)  Mild (>5% Activity) Circulating Factor \_\_\_\_\_ %

Inhibitor  No  Historical  Current Historical Response  Hi  Lo Date of Last Test \_\_\_\_\_

Height \_\_\_\_\_  cm  in Weight: \_\_\_\_\_  kg  lbs Date of Last measurement \_\_\_\_\_

Allergies \_\_\_\_\_  NKDA

HIV  HBV  HCV  Cardiac Disease  Diabetes  Other \_\_\_\_\_  See Attached

Current Medications \_\_\_\_\_  See Attached

Target Joints  No  Yes Explain \_\_\_\_\_

Protocols  Standard Therapy  Pre Surgical Therapy  Continuous Prophylaxis Therapy  Immune Tolerance

**PRESCRIPTION INFORMATION**

**Factor VIII (Recombinate)**  Recombinate  Helixate FS  Kogenate FS  Refacto  Advate  Xyntha

**Factor VIII (Monoclonal)**  Hemofil-M  Monoclote P  Monarc M

**Factor VIII (Other)**  Humate-P  Alphanate SDHT  Koate DVI  Wilate

**Factor IX (Recombinate)**  Benefix

**Factor IX (Monoclonal/High Purity)**  Mononine  Alphanine SDVF

**Factor IX (Other)**  Konyne-80  ProplexT  Bebulin VH  Profiline SD

**Inhibitor Therapies**  Feiba-VH  NovoSeven

**Other** \_\_\_\_\_

Target Dose \_\_\_\_\_ Directions \_\_\_\_\_

Ancillary Supplies Needed \_\_\_\_\_

Dispense as written

**PRESCRIBER INFORMATION**

Prescriber	Specialty	Office Contact	Phone Number
Address	City	State	Zip
Today's Date	Date Needed	I certify that the above therapy is medically necessary and all the above information is accurate to the best of my knowledge.	
Physician's Signature: _____		NPI _____	DEA _____

Refrigerated prescriptions are shipped Mon. - Thurs. via standard overnight service. Saturday delivery requires approval from an Ascend pharmacist. For refills, please call-in or fax 7 days in advance of next appointment.

**CONFIDENTIALITY STATEMENT:** This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone.