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BLEEDING DISORDERS

844-44 AXIVA (2-9482)
844-440-0101

Patient Information

Patient Name: _____ DOB: _____
Sex: ☐Female ☐Male SSN: _____
Language: _____ Wt: _____ ☐kg ☐lbs Ht: _____ ☐cm ☐in
Address: _____
Apt/Suite: _____ City: _____ State: ▼ Zip: _____
Phone: _____ Alternate: _____
Caregiver name: _____ Relation: _____
Local Pharmacy: _____ Phone: _____

Prescriber + Shipping Information

Prescriber Name: _____
NPI: _____
Address: _____
Apt/Suite: _____ City: _____ State: ▼ Zip: _____
Contact: _____
Phone: _____ Alternate: _____
Fax: _____ Email: _____
If shipping to physician: ☐First Fill ☐Always ☐Never

Monthly Master Case Quantity

1° Insurance Plan: _____ Plan ID: _____ Policy Holder: _____ Relation: _____
2° Insurance Plan: _____ Plan ID: _____ Policy Holder: _____ Relation: _____

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis Code:

☐D67 (Type B – Factor IX Deficiency)
☐D68.2 (Hereditary deficiency of other clotting factors)
☐D68.4 (Acquired coagulation factor deficiency)
☐ _____
Date of Diagnosis: _____
Circulating Factor: ____% Target Joints: ☐No ☐Yes _____
Severity: ☐Severe (<1%) ☐Moderate (1 - 5%) ☐Mild (>5%)
Inhibitor Activity: ☐None ☐Historical ☐Current _____ BU/mL

☐D66 (Type A – Factor VIII Deficiency)
☐D68.1 (Type C – Factor XI Deficiency)
☐D68.32 (Hemorrhagic disorder due to extrinsic circulating anticoagulants)
☐D68.0 (Von Willebrand Disease – Check Type: ☐1 ☐2 ☐3
Access: ☐Peripheral ☐PICC ☐Implanted Port ☐Other: _____
Protocol: ☐Pre-Surgical ☐Prophylaxis ☐Immune Tolerance ☐On-demand
Start Date: _____ Start Date: _____

Comorbidities: _____
Concomitant Medications: _____
Allergies: ☐NKDA ☐Other: _____

Prescription

Factor I (Recombinant)	☐RiaSTAP®
Factor VIIa (Recombinant)	☐NovoSeven® RT
Factor VIII (Recombinant)	☐Advate® ☐Adynovate® ☐Afstyla® ☐Eloctate™ ☐HelixatE® FS ☐Jivi® ☐Kogenate® ☐Kovaltry® ☐NovoEight® ☐Nuwiq® ☐Recombinate® ☐Xyntha®
Factor VIII (Human)	☐Hemofil® M
Factor VIII (Human) + VWF	☐Alphanate® SD ☐Humate-P® ☐Koate®DVI ☐Wilate®
Factor IX (Recombinant)	☐Alprolix® ☐Benefix® RT ☐Idelvion® ☐Ixinity® ☐Rixubis® ☐Rebinyn®
Factor IX (Human)	☐AlphaNine® SD ☐Mononine®
Factor X Activator (Human/Recombinant)	☐Hemlibra®
Factor X (Human)	☐Coagadex®
Factor XIII (Human)	☐Corifact®
Factor XIII (Recombinant)	☐Tretten®
Von Willebrand Factor (Recombinant)	☐Vonvendi®
Anti-Inhibitor (Human)	☐Feiba®
Pro-Thrombin Complex (Human)	☐Profilnine® SD
Therapy Regimen for Factor or Inhibitor Products	☐Prophylaxis® _____/week ☐Target Dose: _____IU/kg ☐Dose: _____ IU ± _____ % (Assay variation) # Doses: _____ Refills: _____ ☐Breakthrough bleed ☐Minor: _____ IU ± _____ % ☐Moderate: _____ IU ± _____ % ☐Major: _____ IU ± _____ % # Doses: _____ Refills: _____ ☐Immune Tolerance ☐Target Dose: _____IU/kg ☐Dose: _____ IU ± _____ % (Assay variation) # Doses: _____ Refills: _____
Flushing Protocol	☐Sodium Chloride 0.9% 5-10 mL pre and post medications ☐Heparin _____ Units/mL _____ mL as needed
Ancillary Supplies	☐As needed for proper administration and proper disposal of medication infusion supplies.
Skilled Nursing Visits	☐As needed for IV access, administration and proper clinical monitoring
All nursing services requirements to be completed per pharmacy protocol.	
Other Medications	☐Amicar® Directions: _____ Qty: _____ Refills: _____ ☐Lysteda® Directions: _____ Qty: _____ Refills: _____ ☐Stimate® Directions: _____ Qty: _____ Refills: _____ ☐ Directions: _____ Qty: _____ Refills: _____
Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise:	

Prescriber's Signature: _____ Date: _____

I authorize AXIVA health solutions and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to AXIVA health solutions.