BLUEGRASS PHARMACY | HEMOPHILIA ENROLLMENT FORM

BLUEGRASS Pharmacy
A Member of the Wellpartner Family

FAX FORM TO: 1.866.233.8317 | **PHONE:** 1.855.492.0817 | **EMAIL:** contact@bluegrass-rx.com

Complete the following or include demographic sheet.

1. PATIENT INFORMATION

Name:
Address:
City, State, ZIP:
Primary Phone: - - DOB: / /
Alternate Phone: - - Gender:
Email:
Primary Language: Last Four of SSN:

2. PRESCRIBER INFORMATION

Name:
DEA #: NPI #: State Lic. #:
Group or Hospital:
Address:
City, State, Zip:
Phone: - - Fax: - -
Contact Person: Phone: - -

3. INSURANCE INFORMATION

*Fax copy of **prescription** and **insurance cards** with this form, if available (front and back)*

Primary Insurance Company Name:
Primary Cardholder Name:
Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent
Phone: - - Member ID: Group #:

Secondary Insurance Company Name:
Secondary Cardholder Name:
Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent
Phone: - - Member ID: Group #:

4. DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: / / Ship to: ◯ Patient ◯ Office ◯ Other:

◯ D66 Hereditary factor VIII deficiency
◯ D67 Hereditary factor IX deficiency
◯ D68.1 Hereditary factor XI deficiency
◯ D68.2 Hereditary deficiency of other clotting factors
◯ Factor VII disorder ◯ Factor XIII disorder
◯ D68.Ø Von Willebrand disease
◯ Type 1 ◯ Type 2 ◯ Type 3
◯ D68.3 Hemorrhagic disorder
◯ D68.9 Other specified coagulation defects
◯ Other (Specify):

Height (in/cm): Weight (lb/kg):

Severity: ◯ Severe (<1% activity) ◯ Moderate (<1-5% activity) ◯ Mild (>5% activity)
Circulating Factor Level: _____% Inhibitor? ◯ No ◯ Historical: _____ Current BU
Target Joints: ◯ No ◯ Yes (Specify):

Administration

Nursing needed? ◯ Yes ◯ No Patient trained to self-administer? ◯ Yes ◯ No
◯ MD office to administer to patient ◯ Home health agency coordinated administration

Allergies:
Other Medications:
Is patient interested in patient support programs? ◯ Yes ◯ No

5. PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
◯ Advate ◯ Adynovate® ◯ Alphanate ◯ Alphanine ◯ Alprolix® ◯ Amicar tablet ◯ Amicar syrup ◯ Bebulin ◯ BeneFIX ◯ Coagadex ◯ Corifact ◯ Eloctate® ◯ Epi-Pen ◯ Epi-Pen Jr. ◯ Feiba NF ◯ Heparin ◯ Helixate ◯ Hemofil-M ◯ Humate-P ◯ IXINITY® ◯ Koate-DVI ◯ Kogenate FS ◯ Kovaltry® ◯ Monoclate-P ◯ Mononine ◯ Novoeight® ◯ Novoseven RT ◯ Nuwiq® ◯ Obizur ◯ Profilnine ◯ Recombinate ◯ RiaSTAP® ◯ Rixubis ◯ Stimate ◯ Thrombate III ◯ Xyntha ◯ Wilate ◯ Other:	_____ IU/kg _____ mg/kg _____ mg _____ mcg _____ mL	◯ Prophylaxis: _____ ◯ Immune tolerance: _____ ◯ Breakthrough bleed ◯ Infuse _____ units (+/- 10%) slow IV push every _____ hours/days (circle one) for a total of _____ doses as needed for bleeding episodes. *Contact your physician's office if bleeding does not resolve.* Minor: ◯ _____ IU q _____ hr PRN ◯ Other: _____ Major: ◯ _____ IU q _____ hr PRN ◯ Other: _____	◯ 3 months ◯ 1 month ◯ Other:	◯ 3 months ◯ 1 month ◯ Other:

Ancillary supplies and kits will be provided as needed for administration.

6. PRESCRIBER SIGNATURE

X / /
DISPENSE AS WRITTEN DATE

X / /
PRODUCT SUBSTITUTION PERMITTED DATE