

Treatment Setting	Home by: <input type="checkbox"/> Patient/caregiver <input type="checkbox"/> Option Care nurse <input type="checkbox"/> Other: _____		Referral date: _____	
	<input type="checkbox"/> MD office <input type="checkbox"/> Option Care treatment site <input type="checkbox"/> Other: _____		Need by date/time: _____	
Patient Information Please type or print clearly. (OR fax demographic sheet)	Name: _____			
	DOB: _____		Gender: _____	
	Address: _____			
	City: _____		State: _____	ZIP: _____
	Home phone w/area code: _____		Alternate phone w/area code: _____	
	Caregiver name(s): _____		Caregiver relationship: _____	
Emergency contact name: _____		Phone: _____		
Medical Insurance Information Please attach a copy of card if possible. (OR fax front and back of medical and prescription cards)	Primary insurance: _____		Cardholder name/DOB: _____	Cardholder employer: _____
	ID#: _____		Group#: _____	Phone: _____
	Secondary insurance: _____		Cardholder name/DOB: _____	Cardholder employer: _____
	ID#: _____		Group#: _____	Phone: _____
	Prescription card: _____		Phone: _____	
	ID#: _____	Group#: _____	BIN#: _____	PCN#: _____
Prescriber Information (Unless on faxed Rx)	Name: _____			
	Address: _____		City: _____	State: _____
	Phone w/area code: _____		Fax w/area code: _____	
	NPI: _____	LIC: _____	Supervising name if CPNP or PA: _____	
Medical History	<input type="checkbox"/> D66 - Hereditary Factor VIII Deficiency <input type="checkbox"/> D67 - Hereditary Factor IX Deficiency <input type="checkbox"/> D68.1 - Hereditary Factor XI Deficiency <input type="checkbox"/> D68.2 - Hereditary Deficiency of other Clotting Factors <input type="checkbox"/> D68.0 - von Willebrand's Disease <input type="checkbox"/> D68.311 - Acquired Hemophilia <input type="checkbox"/> D68.8 - Other specified Coagulation Defects <input type="checkbox"/> Other (ICD-10 Code and Description): _____ <input type="checkbox"/> D68.9 - Coagulation Defect, unspecified _____			
	Baseline factor percent: _____ Target joint(s) <input type="checkbox"/> No <input type="checkbox"/> Yes _____ Inhibitor: <input type="checkbox"/> No <input type="checkbox"/> History <input type="checkbox"/> Current _____ BU/mL Inhibitor protocol: _____			
	DNR/Advance directive status: <input type="checkbox"/> Received <input type="checkbox"/> N/A <input type="checkbox"/> Hep B <input type="checkbox"/> Hep C <input type="checkbox"/> HIV <input type="checkbox"/> TB positive Date chest x-ray: _____			
	Drug allergies: _____ Other conditions/other meds: _____			
	Vascular access: <input type="checkbox"/> Peripheral <input type="checkbox"/> Port <input type="checkbox"/> Other: _____ Weight: _____ kg <input type="checkbox"/> lbs Height: _____ cm <input type="checkbox"/> in			
	Prescriptions (OR fax separately)			
	*Target Dose (total units/dose) plus or minus 10% unless otherwise specified			
	Factor VIII recombinant: <input type="checkbox"/> Advate <input type="checkbox"/> Helixate FS <input type="checkbox"/> Kogenate FS <input type="checkbox"/> Recombinate <input type="checkbox"/> Xyntha <input type="checkbox"/> Novoeight <input type="checkbox"/> Adynovate <input type="checkbox"/> Elocate Plasma derived: <input type="checkbox"/> Hemofil M <input type="checkbox"/> Monoclate-P <input type="checkbox"/> Other: _____ Target Dose and directions: _____ Dispense qty: _____ Refills: _____			
	Factor VIII and von Willebrand plasma derived: <input type="checkbox"/> Alphanate <input type="checkbox"/> Humate-P <input type="checkbox"/> Koate-DVI <input type="checkbox"/> Wilate <input type="checkbox"/> Other: _____ Target Dose and directions <input type="checkbox"/> VWF <input type="checkbox"/> Factor VIII: _____ Dispense qty: _____ Refills: _____			
	Factor IX recombinant: <input type="checkbox"/> BeneFix <input type="checkbox"/> Rixubis <input type="checkbox"/> XINITY <input type="checkbox"/> Alprolix <input type="checkbox"/> Other: _____ Plasma derived: <input type="checkbox"/> AlphaNine SD <input type="checkbox"/> Mononine <input type="checkbox"/> Other: _____ Target Dose and directions: _____ Dispense qty: _____ Refills: _____			
Factor X: <input type="checkbox"/> Coagadex <input type="checkbox"/> Other: _____ Target Dose and directions: _____ Dispense qty: _____ Refills: _____				
Factor XIII: <input type="checkbox"/> Corifact <input type="checkbox"/> Other: _____ Activated Prothrombin Complex Concentrates plasma derived: <input type="checkbox"/> Feiba VH <input type="checkbox"/> Other: _____ Target Dose and directions: _____ Dispense qty: _____ Refills: _____				
Prothrombin Complex Concentrates plasma derived: <input type="checkbox"/> Bebulin VH <input type="checkbox"/> Profilnine SD <input type="checkbox"/> Other: _____ Target Dose and directions: _____ Dispense qty: _____ Refills: _____				
Stimate 1 spray in <input type="checkbox"/> one nostril <input type="checkbox"/> each nostril _____ Dispense qty: _____ Refills: _____				
Amicar <input type="checkbox"/> syrup <input type="checkbox"/> 500/1000 mg tab Dose and directions: _____ Dispense qty: _____ Refills: _____				
Other (Continuous infusion, vancomycin, tranexamic acid, rituximab, EpiPen, etc) _____				
Line care: <input type="checkbox"/> Sodium chloride 0.9% 5 - 10 ml <input type="checkbox"/> 3 - 5 ml Heparin (<input type="checkbox"/> 10 units/ml <input type="checkbox"/> 100 units/ml) <input type="checkbox"/> Other: _____ <input type="checkbox"/> Apply 30 - 60 minutes prior to access (<input type="checkbox"/> Emla 30 gram <input type="checkbox"/> LMX 30 gram) <input type="checkbox"/> Other: _____				
Nursing orders: <input type="checkbox"/> Skilled nurse to infuse/teach mixing, infusion, self-monitoring, other aspects of care: _____ Lab orders: _____ Supplies: <input type="checkbox"/> All infusion and prevention supplies as needed and/or _____				
Prescriber Certification	I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.			
	Prescriber's signature required: _____		Date: _____	

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