PREMIER PHARMACY SERVICES

410 Cloverleaf Dr., Baldwin Park, CA 91706
Phone: 800-540-4700 **Fax:** 800-540-3400

Hemophilia and Bleeding Disorders

FACTOR PRESCRIPTION REQUEST

attn: Chronic Infusion Division

Patient Information			**Prescriber Information**		
Patient Name:			Prescriber name:		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Home Ph:	Alt Ph:		Office Ph:	Office Fax:	
DOB:	Gender:	Weight:	DEA:	NPI:	
Drug Allergies:			Contact Person:		

Insurance Information (attach copy of insurance card if available)		
Primary Insurance	Subscriber:	ID#:
	Name of Insurer:	Phone #:
Secondary Insurance	Subscriber:	ID#:
	Name of Insurer:	Phone #:

Diagnosis: ☐Hemophilia A (286.0) ☐Hemophilia B (286.1) ☐vWD (286.4) ☐Other (ICD 9): ______________________ ☐ Inhibitor Present

Venous Access: ☐Peripheral IV ☐Port-a-Cath ☐PICC ☐AV Fistula ☐Other: ____________________________

Nursing Services required: ☐Yes ☐No

℞ **Factor (product name):** ____________________________ **Frequency of use:** ________________ **Refills:** _______

Dosing Regimen:	**Prophylaxis**	**Minor bleed**	**Moderate bleed**	**Severe bleed**
Dose (units or mg)				
Number of doses per month to dispense				

Flush Orders:	**Normal Saline 0.9%**	**Heparin 10u/ml**	**Heparin 100u/ml**	**other**
Before factor dose	ml	ml	ml	ml
After factor dose	ml	ml	ml	ml

Supplies:	**Directions or notes**	**Size**	**Quantity**	**Refills**
Syringes		ml		
Administration set/ infusion line		gauge		
Other				

Ancillary Meds:	**Dose:**	**Directions:**	**Qty:**	**Refills**
Amicar				
Emla				
LMX				
Stimate nasal spray				
DDAVP solution for injection				
Other:				

Additional Comments: ____

PRESCRIBER SIGNATURE ________________________________ **DATE:** ______________

☐ Dispense Brand Name __________MD initials

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