PREMIER
PHARMACY SERVICES

Fax: 800.540.3400
Phone: 800.540.4700

To ePrescribe, send prescription to:
Premier Pharmacy Services
410 Cloverleaf Drive
Baldwin Park, CA 91706

FACTOR PRESCRIPTION REQUEST
Hemophilia and Bleeding Disorders

Ship to: ☐ Patient ☐ Physician ☐ Other (please specify): ______________________________

All supplies, including syringes and needles, will be dispensed if needed.

Patient Information

Patient Name: ______________________________

Gender: ☐ Male ☐ Female DOB: ____________________ SSN: ____________________

Address: ______________________________

City: ______________________________ State: ______________ Zip: ______________

Phone: ______________________________ Alt Phone: ______________________________

Email: ______________________________ Alternate Contact Info: ______________________________

PLEASE ATTACH COPIES OF FRONT AND BACK OF PATIENT'S PRESCRIPTION INSURANCE CARDS AND MOST RECENT LABS

Clinical Information

Diagnosis (ICD-10):
☐ D66 Hereditary Factor VIII Deficiency
☐ D67 Hereditary Factor IX Deficiency
☐ D68.0 Von Willebrand's Disease
☐ D68.311 Acquired Hemophilia
☐ D68.318 Other Hemorrhagic Disorder Due to Intrinsic circulating anticoagulants, antibodies, or inhibitors
☐ D68.8 Other Specified Coagulation Defects
☐ D68.9 Coagulation Defect, Unspecified
☐ D68.2 Hereditary Deficiency of Other Clotting Factors

☐ Other: ______________________________

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

☐ Other: ______________________________

Patient Clinical Information:

Height: __________☐in ☐cm Weight: __________☐lb ☐kg

Allergies: ______________________________

____

Nursing Services Required:
Specialty pharmacy to coordinate injection or infusion training / home health infusion nurse visit necessary? ☐ Yes ☐ No
Site of care: ☐ MD Office ☐ Infusion Clinic ☐ Outpatient Health ☐ Home Health

Injection / Infusion necessary? ☐ Yes ☐ No. If no, date training occurred: ______________________________
Reason: ☐ MD Office training patient ☐ Patient already independent ☐ Referred by MD to alternate training

Prescription Information

Medication		Strength	Dose and Directions	Quantity Refills
☐ Advate ☐ Adynovate ☐ Afstyla ☐ Alphanate ☐ AlphaNine ☐ Alprolix ☐ BeneFIX ☐ Corifact ☐ Ceprotin ☐ Eloctate ☐ Feiba NF ☐ Hemofil-M ☐ Humate-P ☐ Idelvion ☐ Ixinity	☐ Jivi ☐ Koate-DVI ☐ Kogenate ☐ Kovaltry ☐ Novoeight ☐ Nuwiq ☐ Profilnine ☐ Rebinyn ☐ Recominate ☐ Rixubis ☐ Thrombate III ☐ Tretten ☐ Vonvendi ☐ Wilate ☐ Xyntha	__________IU/kg	☐ Prophylaxis: ______________________________ ______________________________ ☐ Breakthrough bleed: Infuse _______ units (+/-10) slow IV push every _________ ☐ hour ☐ days (select one) for a total of _________ doses PRN bleeding episodes. Contact your prescriber's office if bleeding does not resolve Minor: ☐ ______IU every ______ hour PRN ☐ Other: ______________________________ Major: ☐ ______IU every ______ hour PRN ☐ Other: ______________________________ ☐ Immune tolerance: ______________________________ ______________________________	Quantity: ☐ 1 month ☐ Other: ________ Refills: __________

Referral Form Continued on Next Page

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Medication	Strength	Dose and Directions	Quantity Refills
☐ Hemlibra	☐ 30mg/mL ☐ 60mg/0.4mL ☐ 105mg/0.7mL ☐ 150mg/1mL	☐ Initial dose: 3mg/kg sub-Q once weekly for 4 weeks ☐ Maintenance dose: Weight: ___________kg ☐ 1.5mg/kg sub-Q every week ☐ 3mg/kg sub-Q every 2 weeks ☐ 6mg/kg sub-Q every 4 weeks ☐ Other: ______________________	Quantity: ☐ 1 month ☐ Other: ________ Refills: __________
☐ NovoSeven RT	_________mcg/kg	Infuse _______ mcg/kg slow IV push every _______ hours, and/or ______________________ ______________________ Weight: ___________kg	Quantity: ☐ 1 month ☐ Other: ________ Refills: __________
☐ Other: ____________________	____________	______________________	Qty: ____ RF: ____

Flush Orders

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

Ancillary Medication Information

Medication	Strength/Dose	Dose and Directions	Quantity Refills
☐ Amicar	____________	______________________	Qty: ____ RF: ____
☐ Emla Cream	____________	______________________	Qty: ____ RF: ____
☐ Stimate nasal spray	____________	______________________	Qty: ____ RF: ____
☐ DDAVP solution for injection	____________	______________________	Qty: ____ RF: ____
☐ Epinephrine Pen	☐ Adult ☐ Junior	☐ Adult: 0.3mg for patients ≥ 30kg ☐ Junior: 0.15mg for patients 15kg to 30kg Give IM/sub-Q PRN severe allergic reaction – call 911. May repeat in 5-15 minutes as needed.	Qty: 1 box RF: _________
☐ Other: ____________________	____________	______________________	Qty: ____ RF: ____

Supply Orders

Supplies	Directions/Notes	Size	Quantity Refills
☐ Syringes	______________________	__________mL	Qty: ____ RF: ____
☐ Administration set / Infusion line	______________________	________ gauge	Qty: ____ RF: ____
☐ Other: ____________	______________________	____________	Qty: ____ RF: ____

Prescriber Information

PRIOR AUTHORIZATION

Prescriber Name: ______________________________ NPI: ________________ DEA: ________________

Address: ____

City: ______________________ Zip: __________ Tel: ____________________ Fax: ____________________

Contact Person: ______________________________ E-Mail: ______________________________

PRESCRIBER SIGNATURE
(Prescriber, please sign and date below)

No stamps. Signature and date must be completed in prescriber's handwriting.
NY prescriptions must be submitted via e-script.

I authorize Premier Pharmacy and its representatives to act as an agent to initiate and execute prior authorization for the above patient in order to expedite the process, please provide chart notes and most recent labs.

Physician's Signature: ______________________________ ☐ **Dispense as written (DAW) Date:** ______/______/______

IMPORTANT NOTICE: 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.