Physician Prescription Request Form for Hemophilia Drugs

Fax to Pharmacy Services at **855-811-9332**, or call **888-602-3741**
to speak to a representative. ***Form must be completed for processing***.

AmeriHealth Caritas
District of Columbia

Patient Name: _____ Patient ID#: _____

Address: _____ Apt # or Suite #: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Height: _____ Weight: _____lbs = _____Kg Birth Date: _____

Physician Name: _____ NPI #: _____

Address: _____ Apt # or Suite #: _____

City: _____ State: _____ Zip Code: _____

Contact Person: _____Phone #: _____ Fax #: _____

Physician Signature:_____ E Mail:_____

Home Health Company Name: _____ Phone #: _____

Home Health Company Address: _____ Fax #: _____

_____ E Mail:_____

Contact Person: _____

Factor VII

☐ Novoseven #_____1000 µg vials #_____2000 µg vials #_____5000 µg vials #_____8000 µg vials Inhibitor Antibody Titer_____BU

Factor VIII ☐ Recombinate ☐ Hemofil-M ☐ Advate ☐ Alphanate ☐ Xyntha

☐ Kogenate FS ☐ Other_____

____100 ± IU vials # _____ 250 ± IU vials # _____300 ± IU vials # _____ 500 ± IU vials #_____600 ± IU vials # ____1000 ± IU vials # _____ 1600 ± IU vials # ____ 3000 ± IU vials

Factor IX ☐ Benefix ☐ Alphanine

☐ Other_____

_____250 ± IU vials #_____500 ± IU vials # _____1000 ± IU vials # _____2000 ± IU vials

von Willebrand Disease ☐ Stimate Nasal Spray 1.5 mg/mL 2.5mL Spray
☐ Humate-P ☐ Other_____
☐ Wilate

_____250 ± IU vials #_____500 ± IU vials # _____1000 ± IU vials

Total Amount of Factor Requested _____ **IU / µg** **Number or Doses**_____

Total Amount of Factor At Home_____ **IU / µg** **Number or Doses**_____

For Prophylaxis or Episode Please Indicate Weekly Dose Schedule:

Sun: IU/µg **Mon:** IU/µg **Tue**: IU/µg **Wed:** IU/µg **Thu:** IU/µg **Fri:** IU/µg **Sat**: IU/µg

Authorizations are for a maximum of 1 month duration

To Be Administered From (date) _____ **to (date)** _____

Diagnosis:

☐ Hemophilia A [Factor VIII] ☐ Hemophilia B [Factor IX] ☐ von Willebrand Disease ☐ Platelet Function Defect (PFD):

Reason for Use:

☐ Prophylaxis ☐ Episode Site:_____ ☐ Dental Extraction ☐ Surgical Procedure ☐ Other: _____