EAGLET PHARMACY

Hemophilla Referral Form

Toll Free Phone Number : 800-407-7421
Toll Free Fax Number : 800-308-8573

2209 SW 104th St Suite E, Oklahoma City, OK, 73159

This prescription form is to be sent & received via fax

Prescriber:		**NPI:**	
Supervising Physician:		**NPI:**	
Address:		**Tax ID:**	
Phone:		Fax:	
Contact:			

PATIENT INFORMATION

Name:	☐ M ☐ F ☐ Trans M ☐ Trans F ☐ Other	DOB: ___/___/___	SS#: ___-___-___
Street:	City:	State:	ZIP:
Phone:	Alt. Phone:	☐ English ☐ Spanish ☐ Other:	Wt.: Ht.:

** Please include a copy of the front and back of insurance card **

CLINICAL INFORMATION - Please include applicable clinical chart notes

Prescription Type ☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment

Therapy Start Date	Date of Transplant	Date of Discharge	Date Medication Needed

Other/Concomitant Medications (please list)

Allergies ☐ NKDA ☐ Drug Allergies (please list) ☐ Other (please list)

Ship to Address ☐ Home ☐ Prescriber's Office ☐ Other (please list)

Patient Height (cm/in)	Patient Weight (kg/lbs)	Date Obtained

ICD-10 Codes ☐ Kidney (Z94.0) ☐ Kidney/Pancreas (Z94.0/Z94.83) ☐ Heart (Z94.1) Lung (Z94.2) ☐ Heart/Lung (Z94.3) ☐ Liver (Z94.4) ☐ Bone Marrow (Z94.81) ☐ Intestines (Z94.82) ☐ Pancreas (Z94.83) ☐ B25 CMV disease ☐ B25.9 CMV disease, unspecified ☐ Other Code _____ Description _____

PRESCRIPTION INFORMATION - Please Escribe if required by state law

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitutions. This form is not a valid prescription form for writing controlled medications.

Prescription

☐ **New** ☐ **Refill** **Ship by:** ___/___/___ **SHIP TO:** ☐ **Patient's Home** ☐ **Doctor's Office** ☐ **Other:** _____

Factor I (Recombinant)	☐ RiaSTAP®					
Factor VIIa (Recombinant)	☐ NovoSeven® RT	☐ Sevenfact®				
Factor VIII (Recombinant)	☐ Advate®	☐ Adynovate®	☐ Afstyla®	☐ Eloctate™	☐ Esperoct®	
	☐ Jivi®	☐ Kogenate® FS	☐ Kovaltry®	☐ NovoEight®	☐ Nuwiq®	
	☐ Recombinate®	☐ Xyntha®				
Factor VIII (Human)	☐ Hemofil® M	☐ Monarc-M™				
Factor VIII (Human) + VWF	☐ Alphanate® SD	☐ Humate-P®	☐ Koāte® DVI	☐ Wilate®		
Factor IX (Recombinant)	☐ Alprolix®	☐ Benefix® RT	☐ Idelvion®	☐ Ixinity®	☐ Rixubis®	
Factor IX (Human)	☐ AlphaNine® SD	☐ Proplex T				
Factor X Activator (Human/Recombinant)	☐ Hemlibra®					
Factor XIII (Human)	☐ Corifact®					
Factor XIII (Recombinant)	☐ Tretten®					
Von Willebrand Factor (Recombinant)	☐ Vonvendi®					
Anti-Inhibitor (Factor)	☐ Feiba®					
Pro-Thrombin Complex (Human)	☐ Profilnine® SD					

Therapy Regimen for Factor or Inhibitor Products	☐ Prophylaxis_____/week	☐ Breakthrough Bleed	☐ Immune Tolerance
	☐ Target Dose: _____IU/kg	☐ Minor: _____IU ± ____%	☐ Target Dose: _____IU/kg
	☐ Dose: _____IU ± ____%	☐ Moderate: _____IU ± ____%	☐ Dose: _____IU ± ____%
	(Assay Variation)	☐ Major: _____IU ± ____%	(Assay Variation)
	# of Doses:_____ Refills:_____	# of Doses:_____ Refills:_____	# of Doses:_____ Refills:_____

Flushing Protocol	☐ Sodium Chloride 0.9% 5-10 mL pre and post medications	☐ Heparin_____ Units/mL _____mL as needed
Ancillary Supplies	☐ As needed for proper administration and proper disposal of medication and infusion supplies	
Skilled Nursing Visits	☐ As needed for IV access, administration, and proper clinical monitoring	

All nursing services requirements to be completed per pharmacy protocol

Other Medications	☐ Amicar®	Directions:_____	Qty:_____	Refills: _____
	☐ Lysteda®	Directions:_____	Qty:_____	Refills: _____
	☐ Stimate®	Directions:_____	Qty:_____	Refills: _____
	☐ _____	Directions:_____	Qty:_____	Refills: _____

PRESCRIBER SIGNATURE

To Prescriber: By signing this form and utilizing our services, you are also authorizing Eaglet Pharmacy to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Prescriber: **Date:** ___/___/___

CONFIDENTIALITY NOTICE