Hemophilia
Prescription Referral Form

Phone:1-877-592-7988
Fax: 1-800-787-0874

Rosemont
Specialty Pharmacy
www.rosemontspecialtyrx.com

Six Simple Steps to Submitting a Referral

❶ PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: ____________________
Address: ____________________
City, State, ZIP: ____________________
Preferred Contact Method: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)
Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
Primary Phone: __________ ☐ Home ☐ Cell ☐ Work
Alternate Phone: __________ ☐ Home ☐ Cell ☐ Work
DOB: __________ Gender: ☐ Male ☐ Female
Email: ____________________
Last Four of SSN: __________ Primary Language: __________

❷ PRESCRIBER INFORMATION

Prescriber's Name: ____________________
State License #: __________ NPI #: __________
DEA #: __________
Group or Hospital: ____________________
Address: ____________________
City, State, ZIP: ____________________
Phone: ____________________
Fax: ____________________
Contact Person: ____________________
Contact's Phone: ____________________

❸ INSURANCE INFORMATION

Please fax copy of prescription and insurance cards with this form, if available (front and back)
Please fax prescription for drug, flushes and supplies

❹ DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: __________
Ship to: ☐ Patient ☐ Office ☐ Other: __________

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
☐ Other Code: ______ Description: ____________________
For additional ICD-10 information, please visit CVSspecialty.com/ICD10

Patient Clinical Information:
Allergies: ____________________ Weight: __________ lb/kg Height: __________ in/cm

Nursing:
Specialty Pharmacy to coordinate injection training/home health nurse visit as necessary? ☐ Yes ☐ No
Site of Care: ☐ MD office ☐ Infusion Clinic ☐ Outpatient Health ☐ Home Health

❺ PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY	REFILLS
☐ Advate® ☐ Adynovate ☐ Afstyla® ☐ Alphanate® ☐ Eloctate™ ☐ Helixate® ☐ Hemofil-M ☐ Koate®-DVI ☐ Kogenate® FS ☐ Kovaltry® ☐ Monoclate-P® ☐ Novoeight® ☐ Nuwiq® ☐ Recombinate® ☐ Xyntha® ☐ Feiba NF ☐ Humate-P® ☐ Vonvendi® ☐ Wilate® ☐ AlphaNine® ☐ Alprolix® ☐ Bebulin® ☐ BeneFIX® ☐ Idelvion® ☐ IXINITY® ☐ Mononine® ☐ Profilnine® ☐ Rixubis ☐ Corifact® ☐ Tretten® ☐ Ceprotin ☐ Thrombate III®	_____ IU/kg	☐ Prophylaxis: __________ ☐ Immune Tolerance: __________ ☐ Breakthrough Bleed: Infuse _____ units (+/- 10%) slow IV push every _____ hours / days (circle one) for a total of _____ doses as needed for bleeding episodes. Contact your physician's office if bleeding does not resolve. Minor: ☐ _____ IU q _____ hr PRN ☐ Other: __________ Major: ☐ _____ IU q _____ hr PRN ☐ Other: __________	☐ 1 mo ☐ 3 mo ☐ _______	☐ 1 year ☐ _____
☐ NovoSeven® RT	_______ mg	Infuse _____ mg slow IV push every _____ hours, and/or __________		
☐ Amicar® Tablet ☐ Amicar® Syrup	_____ mg/kg			
☐ Stimate®	☐ 150 mcg ☐ 300 mcg	☐ Weight <50kg: Single spray in one nostril ☐ Weight >50kg: Single spray in each nostril (2 sprays total)		
☐ Normal Saline		Access Device: ☐ Port ☐ PICC ☐ PIV ☐ Butterfly ☐ Other: __________ — _____ mL every __________		
☐ Heparin	☐ 10 IU/mL ☐ 100 IU/mL	_____ mL every __________		
☐ Epi-Pen® ☐ Epi-Pen Jr.®		☐ PRN anaphylaxis ☐ Other: __________	☐ 1 Pen ☐ 2 Pens ☐ _____	

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

PHYSICIAN SIGNATURE REQUIRED

x____________________ (Date)
PRODUCT SUBSTITUTION PERMITTED

x____________________ (Date)
DISPENSE AS WRITTEN

I authorize Rosemont Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressed and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient do not distribute or copy this fax. Please notify the sender immediately if you received this document in error and destroy this document immediately.