Hemophilia
Prescription Referral Form
ESCRIBE #: 5700174
Phone: 1.877.592.7988
Fax: 1.800.787.0874

Rosemont Specialty Pharmacy

www.rosemontspecialtyrx.com

URAC ACCREDITED Specialty Pharmacy Expires 01/01/2020

1. Patient Information

Patient Name:	SSN:	DOB:	
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Email Address:	
Sex: ☐Male ☐Female	Height:	Weight: ☐ lbs. ☐ kg.	Known Allergies:

2. Insurance Information:

Please fax front and back copy of all Insurance cards (Prescription and Medical)

3. Diagnosis/Clinical Information:

Please fax recent clinical notes, labs, and tests with the prescription to expedite the Prior Authorization

Diagnosis:	ICD 10:
Nursing:	Specialty Pharmacy to coordinate injection training/home health nurse visits as necessary? ☐ Yes ☐ No Site of care: ☐ MD office ☐ Infusion Clinic ☐Outpatient Health ☐Home Health

4. Prescription Information: For IV medications attach a copy of your prescription

Medication	Strength	Dose & Directions	Quantity	Refills
☐ Advate® ☐ Kogenate® FS ☐ Feiba NF ☐ Adynovate ☐ Kovaltry® ☐ Afstyla® ☐ Monoclate-P® ☐ Humate-P® ☐ Alphanate® ☐ Novoeight® ☐ Vonvendi® ☐ Eloctate™ ☐ Nuwiq® ☐ Wilate® ☐ Helixate® ☐ Recombinate® ☐ Hemofil-M ☐ Xyntha® ☐ Koate® -DVI	____ 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 ☐ _____
☐ AlphaNine® ☐ IXINITY® ☐ Corifact® ☐ Alprolix® ☐ Mononine® ☐ Tretten® ☐ Bebulin® ☐ Profilnine® ☐ Ceprotin ☐ BeneFIX® ☐ Rixubis ☐ Thrombate III® ☐ Idelvion®				
☐ **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 ☐ _____	

Ship to: ☐ Patient ☐ Office ☐ Other

5. Physician Information:

Prescriber Name:	Prescriber NPI:	DEA#:	
Address:	City:	State:	Zip:
Primary Office Contact:	Fax Number:	Phone Number:	
Office Contact Email:			

Prescriber Signature: Prescriber, please sign and date below

*I authorize Rosemont Specialty Pharmacy and it's representatives to act as my authorized agent to secure coverage and initaite prior authorization process for my patient(s), and to sign any necessary forms on my behalf as authorized agents, including the recipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fullfill this prescription, I further authorize to forward this information and any related to coverage of the product to another pharmacy of patient's choice or in the patient's insurer's provider network.

☐ Dispense as written ☐ Substitution Permissible

Prescriber's Signature _____ Date _____

This prescription is valid only if transmitted by facsimile machine by a licensed prescriber.