

Bleeding Disorder Referral Form

Fax: 866-523-5406

Phone: 800-829-3975
bioplusrx.com/infusion

Ship To: In Office Infusion Suite At Home Other _____

PATIENT INFORMATION

Patient Name:	SSN:	DOB:		
Address:	City:	State:	Zip:	
Home Phone:	Height:	Weight:	Gender:	Male Female
Cell Phone:	Email Address:			

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance Co:	Policy Holder:	Relationship:	Policy #:	Group #:
Secondary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:

CLINICAL INFORMATION

Diagnosis (ICD-10)

D66 Hereditary Factor VIII Disorder (Hemophilia A) Severity mild moderate severe

D76 Hereditary Factor IX Disorder (Hemophilia B) Severity mild moderate severe

D68.0 Von Willebrand Disease Type: 1 2A 2B 2M 2n 3

D68.311 Acquired Hemophilia

D68.9 Coagulation defect, unspecified

D68.2 Hereditary deficiency of other clotting factors

D68.318 Other hemorrhagic disorder due to intrinsic circulating anticoagulants, antibodies, or inhibitors

Other _____

Date of Diagnosis: _____ Comorbidities: _____

ALLERGIES: NKDA Other _____

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

CLOTTING FACTOR ORDERS

Brand Name: _____ Dose: _____ Qty: _____ Frequency: _____

Brand Name: _____ Dose: _____ Qty: _____ Frequency: _____

Dosage: Mild units/ kg _____ Severe units/ kg _____

Prophylaxis: Dispense _____ dose/week for a duration of _____ months Episodic: Dispense _____ doses for mild/ _____ doses for severe

OTHER MEDICATION

Amicar[®] Directions: _____ Qty: _____ Refills: _____

Lysteda[®] Directions: _____ Qty: _____ Refills: _____

Stimate[®] Directions: _____ Qty: _____ Refills: _____

_____ Directions: _____ Qty: _____ Refills: _____

VASCULAR ACCESS DEVICE: Peripheral Catheter PICC Port Other (describe/# of lumens): _____

Flush Orders: (If IV ordered the following flush protocols will be followed)

Sodium Chloride 0.9% **Other** _____

Peripheral Line: 3 ml before each dose and 3 ml after each dose and prn

Central Line: 5 - 10 ml before each dose and 5 - 10 ml after each dose and prn

As required by your state, Prescriber to check "Dispense as written" or handwritten "Brand Medically Necessary" and sign to prevent generic substitution. Dispense as written

NURSING

Nursing Agency: _____ **Phone:** _____

Skilled Nursing Visits for Bleeding Disorder Intravenous therapy and education. To provide education related to the disease process and therapy. To provide an assessment of patient's general overall health status. To provide skilled nursing visits PRN for additional education and support.

PHYSICIAN INFORMATION

Prescriber Name:	Phone:	Fax:
Office Contact:	Email:	
Address:		
NPI #:	Tax ID #	
Prescriber Signature:	Date	

Your signature authorizes BioPlus Specialty Pharmacy Services, LLC, and their network of pharmacies, MedScripts Medical Pharmacy, River Medical Pharmacy, and Route 300 Pharmacy (the "BioPlus Pharmacies"), to act on your behalf to obtain prior authorization, including appeals and peer to peer reviews, for the prescribed medications. We will also pursue available copy and financial assistance on behalf of your patients.

BioPlus Specialty Pharmacy 376 Northlake Blvd., Altamonte Springs, FL 32701 **BioPlus Specialty Pharmacy** 100 Southcenter Ct., Suite 100, Morrisville, NC 27560

BioPlus Specialty Pharmacy 13925 Yale Ave, Suite 145, Irvine, CA 92620 **MedScripts Medical Pharmacy** 1325 Miller Rd., Suite K, Greenville, SC 29607

River Medical Pharmacy 4752 Research Drive, San Antonio, TX 78240 **Route 300 Pharmacy** 1208 Route 300, Suite 103, Newburgh, NY 12550

BSP210816

Sales Person:

197101