BioPlus® Infusion
A CAREPATHrx Company

Santa Barbara Pharmacy

E-prescribe the *Fast & Easy* way: select **BioPlus Specialty Pharmacy** from your EHR!

Bleeding Disorder Referral Form

Fax: 866-523-5406

Phone: 800-829-3975
bioplusinfusion.com

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%**
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
☐ **Other** _____
_____
_____

As required by your state, Prescriber to check "Dispense as written" or handwrite "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, Route 300 Pharmacy, and Santa Barbara Specialty 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 copay and financial assistance on behalf of your patients. **BioPlus Specialty Pharamcy** 376 Northlake Blvd., Altamonte Springs, FL 32701 **BioPlus Specialty Pharmacy** 100 Southcenter Ct., Suite 100, Morrisville, NC 27560
BioPlus Specialty Pharmacy 13925 Yale Ave, Suite145, 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
Santa Barbara Specialty Pharmacy 4690 Carpinteria Ave, Ste B, Carpinteria, CA 93013

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Sales Person:

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