



# 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%**  **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, 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 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  
**Santa Barbara Specialty Pharmacy** 4690 Carpinteria Ave, Ste B, Carpinteria, CA 93013

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**Sales Person:****197101**