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

BioPlus® Infusion | Santa Barbara Pharmacy

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 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	

BSP230427

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Sales Person: