

Prescription & Enrollment Form Hemophilia



(800) 962-6339 Office
(866) 755-6339 Fax

Patient Information

Last Name		First Name	
Social Security #		Date of Birth	
Parent or Guardian			
Home Phone		Other Contact Phone	
Home Address			
City, State, Zip			

Insured Information

Primary Insurance (Fax copy of card - both sides)	
Subscriber's Name	Relationship to Patient
Policy #	Group #
Primary Insurance Phone	
Prescription Card (Fax copy of card - both sides)	
Secondary Insurance	Policy #

DIAGNOSIS/MEDICAL INFORMATION (Please specify primary and secondary diagnosis)

<input type="checkbox"/> 286.0 Hemophilia A	<input type="checkbox"/> 286.4 von Willebrands
<input type="checkbox"/> 286.1 Hemophilia B	<input type="checkbox"/> Other ICD 9
Severity: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	Allergies:
Circulating Factor Level: % date	
Protocols: <input type="checkbox"/> Primary Prophylaxis <input type="checkbox"/> Secondary Prophylaxis <input type="checkbox"/> Preventative <input type="checkbox"/> Other	
New to therapy: <input type="checkbox"/> yes <input type="checkbox"/> no If no, date therapy began	Date of diagnosis:

PRESCRIPTION INFORMATION

<u>Medication</u>	<u>Dose/Frequency</u>	<u>Quantity</u>	<u>Refills</u>
<input type="checkbox"/> Anti-Hemophilic Factor (please specify)			
<input type="checkbox"/> Anti-Inhibitor coagulant complex (please specify)			
<input type="checkbox"/> DDAVP® or Stimate®			
<input type="checkbox"/> Amicar®			
<input type="checkbox"/> Other Supplies Needed			

DELIVERY INSTRUCTIONS

<input type="checkbox"/> Physician's Office	<input type="checkbox"/> Patient's Home	<input type="checkbox"/> Other	Date Medication Needed:
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Physician's Name (Please Print) _____

Physician's Address _____

Phone _____ Fax _____

Dr.'s Office Contact Name _____

Physician's Signature _____ Date _____

Physician's DEA# _____

License # _____ NPI _____

Fax completed form to Medex BioCare (866) 755-6339