

## Bleeding Disorder Therapy Order Form

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**1. Please submit with form**

- Copy of insurance card ● Patient demographics ● History & physical ● Recent clinic notes
- Labs pertaining to therapy (ex. factor levels, inhibitor testing, or other documentation supporting diagnosis)

**2. Patient information:** Male Female Height: \_\_\_\_\_ in cm Weight: \_\_\_\_\_ lbs kg  
 Allergies: \_\_\_\_\_ NKDA Line type: PIV PICC Port No. of lumens  
 Is patient new to this therapy? No Yes History of inhibitor? No Yes:  
 Is patient/caregiver independent with infusing factor? Yes No Nursing services needed? Yes No  
 When is medication needed (upcoming procedure, active bleeding, etc.):

**3. Diagnosis and Clinical Information**

**ICD-10 Code (required):** Factor X deficiency  
 Hemophilia A (Factor VIII) Mild Mod Severe Factor XIII deficiency  
 Hemophilia B (Factor IX) Mild Mod Severe Glanzmann’s Thrombasthenia  
 Von Willebrand, type 1 2 3 Subtype: Wiskott-Aldrich Syndrome  
 Factor VII deficiency Other:

**4. Prescription Information**

Factor Replacement Therapy (Dose dispensed may be +/-10% unless otherwise specified)	
<b>Prophylaxis</b>	Product: _____ Dose: _____ units VWF:RCo Give IV once every _____ days week(s) Other: _____ Dispense: 1 month supply / Refill x _____ 6 months 1 year Other:
<b>On-Demand</b> (PRN bleeding, procedure, or as directed)	Product: _____ Dose: _____ units VWF:RCo Give IV once every _____ hours days as needed for bleed, procedure, or as directed. Other: _____ Dispense: total doses (OR: minor doses, major doses) / Refill x _____ Patient to keep doses in stock / Keep at least 3 day supply in home
<input type="checkbox"/> <b>Other</b>	Product: _____ Dose: _____ units VWF:RCo for IV administration Frequency / directions: _____ Dispense: _____ doses / Refill x _____ Other:
<b>Administration</b>	<input checked="" type="checkbox"/> RN (or caregiver/patient if independent) to start peripheral IV or use existing CVC <input checked="" type="checkbox"/> Flush IV catheter with NS & heparin, if indicated, per PromptCare policy and procedure Other: _____

Hemlibra (Emicizumab) Therapy	
<b>Loading Doses</b>	3 mg/kg once weekly for 4 weeks Other: _____ Dosing weight: _____ kg Begin maintenance dose _____ weeks after final loading dose Dispense: Quantity sufficient to complete loading dose regimen OR _____ doses/No refills
<b>Maintenance Dose</b>	1.5 mg/kg weekly 3 mg/kg every 2 weeks 6 mg/kg every 4 weeks Other: _____ Dosing weight: _____ kg Dispense 1 month supply / Refill x _____

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Oral Medications	
<b>Medication</b>	Aminocaproic acid 0.25 g/mL oral <b>solution</b> Aminocaproic acid <b>tablets</b> ( 500 mg or 1000 mg tablets) Tranexamic acid 650 mg tablets
<b>Directions</b>	Give _____ mg mg/kg mL by mouth every _____ hours as needed for bleeding, procedure, or as directed. Other:
<b>Quantity</b>	Dispense: _____ <b>tablets</b> OR _____ <b>mL</b> OR: _____ / Refill x

Desmopressin (DDAVP)	
<b>Subcutaneous injection</b> (desmopressin 4 mcg/mL)	Give _____ mcg mcg/kg mL subcutaneously, frequency: Give one dose 30 to 60 minutes prior to procedure Other: Dispense _____ dose(s) / Refill x
<b>Nasal spray</b> (desmopressin 1.5 mg/mL)	<input checked="" type="checkbox"/> Dose based on patient weight as follows: <ul style="list-style-type: none"> <li>Weight &lt;50 kg: administer 150 mcg (1 spray) in a <b>single</b> nostril</li> <li>Weight ≥50 kg: administer 150 mcg (1 spray) in <b>each</b> nostril (total dose 300 mcg)</li> </ul> Directions: Give one dose as needed for bleeding, may repeat after 8-12 hours then daily up to a maximum of 3 days Give one dose 2 hours prior to procedure Other: Dispense 1 bottle / Refill x

Dispense all medical supplies necessary for administration of prescribed medications

Provide skilled nursing to administer/teach preparation and infusion of prescribed medications

Other:

**5. Adverse Reaction Orders** (if applicable):

**6. Prescriber Information**

Prescriber Name:

Address:

Phone:

License #:

Office Contact:

City:

Fax:

State:

Zip:

DEA #:

NPI:

\_\_\_\_\_  
**Physician Signature (Substitution Permitted)**

**Date**

\_\_\_\_\_  
**Physician Signature (Dispense as Written)**

**Date**

*By signing I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment. PromptCare has my permission to contact the patient's health plan to obtain any authorizations necessary to enable it to receive payment for services.*