

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, 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):** _____
☐ Hemophilia A (Factor VIII) ☐ Mild ☐ Mod ☐ Severe
☐ Hemophilia B (Factor IX) ☐ Mild ☐ Mod ☐ Severe
☐ Von Willebrand, type ☐ 1 ☐ 2 ☐ 3 ☐ _____
☐ Factor VII deficiency
☐ Factor X deficiency
☐ Factor XIII deficiency
☐ Glanzmann's Thrombasthenia
☐ Wiskott-Aldrich Syndrome
☐ Other: _____

4. Prescription Information

Factor Replacement Therapy	
☐ Prophylaxis	Product: _____ Dose: _____ ☐ units ☐ VWF:RCo Give IV once every _____ ☐ days ☐ week(s) ☐ Other: _____ Dispense: 1 month supply / Refill x ☐ 6 months ☐ 1 year ☐ Other: _____
☐ On-Demand (PRN bleeding, procedure, or as directed)	Product: _____ Dose: _____ ☐ units ☐ VWF:RCo Give IV once every _____ ☐ hours ☐ days PRN bleed, procedure, or as directed Other: _____ Dispense: _____ total doses (OR: _____ minor doses, _____ major doses) / Refill x _____ <i>Optional:</i> Patient to keep _____ doses in stock / ☐ Keep at least 3 day supply in home
☐ Other	Product: _____ Dose: _____ ☐ units ☐ VWF:RCo IV Frequency / directions: _____ Dispense: _____ doses / Refill x _____ Other: _____
Administration	☒ RN (or caregiver/patient if independent) to start peripheral IV or use existing CVC ☒ Flush IV catheter with NS & heparin, if indicated, per PromptCare policy and procedure ☐ Other: _____

Hemlibra (Emicizumab) Therapy	
☐ Loading Doses	☐ 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 regiment OR _____ doses/No refills
☐ Maintenance Dose	☐ 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 _____

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

Desmopressin (DDAVP)	
☐ Subcutaneous injection (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 _____
☐ Nasal spray (desmopressin 1.5 mg/mL)	☒ Dose based on patient weight as follows: - Weight <50 kg: administer 150 mcg (1 spray) in a single nostril - Weight ≥50 kg: administer 150 mcg (1 spray) in each nostril (total dose 300 mcg) 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

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

6. **Prescriber Information**

Prescriber Name: _____ Office Contact: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____
 License NO.: _____ DEA NO.: _____ NPI: _____

Physician Signature (Substitution Permitted)

 Date

Physician Signature (Dispense as Written)

 Date