Bleeding Disorders referral form

accredo®

Patient info

Patient name		Phone #
Address		
DOB	Sex	Marital status
Patient representative		

Medicaid

Complete this section for Medicaid patients ONLY

Last 4 digits of SSN _____ OR Medicaid ID #_____

Primary insurance

Primary insurance		Phone
Name of insured		Relationship
Last 4 digits of insured SSN	DOB	Employer
Group #	Policy #	Member #
Prescription/drug card company		Phone
Rx BIN #	Group #	Policy ID

Secondary insurance

Secondary insurance		Phone
Name of insured		Relationship
Last 4 digits of insured SSN	DOB	Employer
Group #	Policy #	Member #
Prescription/drug card company		Phone
Rx BIN #	Group #	Policy ID

Clinical

Bleeding disorder type: ☐ A ☐ B ☐ vWD ☐ Other _____ Severity: ☐ Mild ☐ Moderate ☐ Severe ☐ Type vWD_____	Height	Weight
IV access: ☐ PIV/buttterfly ☐ PICC ☐ Implanted port ☐ Central line		Inhibitor: ☐ No ☐ Yes (____B.U.)
Target joint(s): ☐ No ☐ Yes Location		Allergies
Additional clinical information		

41 Rachel Drive, Suite 1 | Nashville, TN 37214 | **Phone: 866.712.5007** | **Fax: 800.330.0756**

Please fax your completed form, along with a copy of the front and back of the patient's insurance ID cards, to: 800.330.0756.

Questions? Please call 866.712.5007.

CRP1807-A0306

Bleeding Disorders referral form

accredo®

Patient info

Patient name	Phone #
Address	
DOB	

Clotting factor orders—Complete this form OR attach prescription below.

Brand name	Dose	Qty	Frequency
Brand name	Dose	Qty	Frequency

Dosage: Mild units/kg _____	Severe units/kg _____
Prophylaxis: Dispense _____ doses/week for a duration of _____ months	
Episodic: Dispense _____ doses for mild / _____ doses for severe	

Ancillary medications/supplies/nursing

☐ *Amicar®* _____mg Directions	☐ Heparin _____units/mL _____mL flush
☐ *Stimate®* 1.5 mg/mL spray in ☐ each ☐ both nostril(s), as directed	☐ Saline _____ mL _____mL flush
☐ *Emla®* Apply topically as needed to IV site 30–60 minutes prior to insertion prn. _____	
☐ *LMX™* Apply topically as needed to IV site 30–60 minutes prior to insertion prn. _____	
☐ *Cryo-Cuff®* to be applied to affected site/joint prn _____. Site _____	
☐ Skilled nursing visits to be provided for infusions ☐ Skilled nursing visits to be provided for teaching	
☐ Other	

Prescription

Prescriber name and title		Office contact	
Address			
Phone #		Fax #	
License #	UPIN #	NPI #	DEA #

Attach prescription form here.

Refills _____ Refill x _____ year/month

Date _____ Time _____

(Physician attests this is his/her legal signature. NO STAMPS.) By signing, I certify that the above therapy is medically necessary.

Prescriber signature _____ _____

Dispense as written Substitution allowed

If shipped to phycician's office, physician accepts on behalf of patient for administration in office.

This prescription is valid only if transmitted by means of a facsimile machine.

41 Rachel Drive, Suite 1 | Nashville, TN 37214 | **Phone: 866.712.5007** | **Fax: 800.330.0756**

Please fax your completed form, along with a copy of the front and back of the patient's insurance ID cards, to: 800.330.0756.

Questions? Please call 866.712.5007.

CRP1807-A0306