

**Hemophilia & Bleeding Disorders
Enrollment Form**

Superior Biologics
Fax Referral To: 914-747-1170



Date: _____

Phone: 855-747-1150

PATIENT INFORMATION

Patient Name: _____
 Address: _____
 City, State, Zip: _____
 Home Phone: _____
 Cell Phone: _____
 Alternate Phone: _____
 Date of Birth: _____ Gender: M F

PRESCRIBER INFORMATION

Prescriber Name: _____
 Address: _____
 City, State, Zip: _____
 Phone: _____
 Fax: _____
 DEA#: _____ NPI#: _____
 Contact Person: _____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card)

Primary Insurance: _____ ID#: _____ Group: _____
 Secondary Insurance: _____ ID#: _____ Group: _____
 Prescription Card: _____ ID#: _____ BIN: _____ PCN: _____ Group: _____

DIAGNOSIS

- D66 Hemophilia A (Factor VIII deficiency)
- D67 Hemophilia B (Factor IX deficiency)
- D68.1 Hemophilia C (Factor XI deficiency)
- D68.2 Hereditary Deficiency of other clotting factors
- 68.0 von Willebrand Disease
- D69.9 Hemorrhagic Condition, Unspecified
- D68.4 Acquired Coagulation Factor Deficiency
- D68.8 Other Specified Coagulation Defects
- Other: _____

PATIENT EVALUATION

Severity:

- Severe (<1% activity) Moderate (1-5% activity) Mild (>5% activity)

- Patient Weight: _____ Kg/Lbs Height: _____ Inches/CM
- Allergies: _____
- Access: Port PICC PIV Butterfly Other: _____
- Nursing Coordination:
 - Pharmacy to coordinate home health nursing visit as necessary: Yes No
 - Home health nursing coordination not necessary. Reason:
 - MD Office to administer to Patient Home health nursing already

PRESCRIPTION INFORMATION

Medication	Directions	Quantity	Refills
<input type="checkbox"/> Advate <input type="checkbox"/> Adynovate <input type="checkbox"/> Alphanate <input type="checkbox"/> Eloctate <input type="checkbox"/> Helixate <input type="checkbox"/> Hemofil-M <input type="checkbox"/> Koate-DVI <input type="checkbox"/> Kogenate FS <input type="checkbox"/> Monoclate-P <input type="checkbox"/> Nuwiq <input type="checkbox"/> NovoEight <input type="checkbox"/> Recombinate <input type="checkbox"/> Xyntha <input type="checkbox"/> Alphanine <input type="checkbox"/> Alprolix <input type="checkbox"/> Bebulin <input type="checkbox"/> BeneFIX <input type="checkbox"/> Ixinity <input type="checkbox"/> Mononine <input type="checkbox"/> Profilnine <input type="checkbox"/> Rixubis <input type="checkbox"/> Humate-P <input type="checkbox"/> Wilate <input type="checkbox"/> Feiba NF <input type="checkbox"/> Novoseven RT	<input type="checkbox"/> Prophylaxis <ul style="list-style-type: none"> • Infuse _____ Units (+/-10%) slow iv-push every _____ <input type="checkbox"/> Breakthrough Bleed <ul style="list-style-type: none"> • Infuse _____ Units (+/-10%) slow iv-push every _____ hours/days (circle one) for a total of _____ doses As Needed for bleeding episodes. Minor: <input type="checkbox"/> _____ IU every _____ hour/day PRN Major: <input type="checkbox"/> _____ IU every _____ hour/day PRN <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 month <input type="checkbox"/> 3 month <input type="checkbox"/> Specify _____	<input type="checkbox"/> 1 Year <input type="checkbox"/> Other _____

Amicar Tablet / Syrup Directions: _____ Qty: _____ Refill _____

NaCl 0.9% Flush Heparin 10 u/ml Flush Heparin 100 u/ml Flush (Direction/Qty. Per flush protocol)

Prescriber Signature: _____

Date: _____

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