REALO Rx SPECIALTY CARE PHARMACY

BLEEDING DISORDER PRESCRIPTION REFERRAL FORM

Community Consultant Contact:

Fax referral to: 844-814-1944 Phone: 844-814-1943
Email referral form to: connect@realospecialtycare.com
For additional forms, visit realospecialtycare.com.

PATIENT INFORMATION

Patient Name: ________ ❑Male ❑Female SS#: ________ DOB: ________
Address: ________ City, State, Zip: ________
Primary Phone: ________ ❑Home ❑Cell ❑Work Alternate Phone: ________ ❑Home ❑Cell ❑Work
Email: ________ Height: ________ Weight: ________
Allergies: ________ Comorbidities: ________

PRESCRIBER INFORMATION

Prescriber Name: ________ Office Contact: ________
Address: ________ City, State, Zip: ________
Phone: ________ Fax: ________
NPI: ________ DEA: ________

SHIPPING INFORMATION

Ship To: ❑ Patient ❑ Physician/Clinic ❑ Other: ________

DIAGNOSIS AND CLINICAL INFORMATION (Please send clinical notes, labs, and/or other supporting documents)

❑ D67 (Type B – Factor IX Deficiency)
❑ D68.2 (Hereditary deficiency of other clotting factors)
❑ D68.4 (Acquired coagulation factor deficiency)
❑ Other: ________
❑ D66 (Type A – Factor VIII Deficiency)
❑ D68.1 (Type C – Factor XI Deficiency)
❑ D68.32 (Hemorrhagic disorder due to extrinsic circulating anticoagulants)
❑ D68.0 (Von Willebrand Disease – Check Type: ❑1 ❑2 ❑3)

Date of Diagnosis: ________
Circulating Factor: ________ % Target Joints: ❑ No ❑ Yes ________
Severity: ❑ Severe (<1%) ❑ Moderate (1-5%) ❑ Mild (>5%)
Inhibitor Activity: ❑ None ❑ Historical ❑ Current________ BU/mL

Access: ❑ Peripheral ❑ PICC ❑ Implanted Port ❑ Other ________
Protocol: ❑ Pre-Surgical ❑ Prophylaxis ❑ Immune Tolerance ❑ On-demand
Start Date: ________ End Date: ________

PRESCRIPTION INFORMATION

Product class	Products
Factor I (Recombinant)	❑ RiaSTAP®
Factor VIIa (Recombinant)	❑ NovoSeven® RT
Factor VIII (Recombinant)	❑ Advate® ❑ Adynovate® ❑ Afstyla® ❑ Eloctate™ ❑ Helixate® FS ❑ Jivi® ❑ Kogenate® FS ❑ Kovaltry® ❑ NovoEight® ❑ Nuwiq® ❑ Recombinate® ❑ Xyntha®
Factor VIII (Human)	❑ Hemofil® M
Factor VIII (Human) + VWF	❑ Alphanate® SD ❑ Humate-P® ❑ Koāte® DVI ❑ Wilate®
Factor IX (Recombinant)	❑ Alprolix® ❑ Benefix® RT ❑ Idelvion® ❑ Ixinity® ❑ Rixubis® ❑ Rebinyn®
Factor IX (Human)	❑ AlphaNine® SD ❑ Mononine®
Factor X Activator (Human/Recombinant)	❑ Hemlibra®
Factor XIII (Human)	❑ Corifact®
Factor XIII (Recombinant)	❑ Tretten®
Von Willebrand Factor (Recombinant)	❑ Vonvendi®
Anti-Inhibitor (Human)	❑ Feiba®
Pro-Thrombin Complex (Human)	❑ Profilnine® SD

Therapy Regimen for Factor or Inhibitor Products			
	❑ Prophylaxis ________/week	❑ Breakthrough bleed	❑ Immune Tolerance
	❑Target Dose: ________IU/kg	❑Minor: ________IU ± _____%	❑Target Dose: ________IU/kg
	❑Dose: ________IU ± _____% (Assay variation)	❑Moderate: ________IU ± _____%	❑Dose: ________IU ± _____% (Assay variation)
		❑Major: ________IU ± _____%	
	# Doses: ________ Refills: ________	# Doses: ________ Refills: ________	# Doses: ________ Refills: ________

Flushing Protocol: ❑ Sodium Chloride 0.9% 5-10 mL pre and post medications ❑ Heparin ________Units/mL ________mL as needed

Prescriber Signature: I authorize Realo Specialty Care Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Dispense As Written - Signature	Date	Substitution Permissable - Signature	Date

PLEASE FAX COPY OF INSURANCE CARD (FRONT + BACK) AND MEDICATION LIST TO 844-814-1944.

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