CenterWell Specialty Pharmacy®

Hemophilia Prescription Request

E-prescribe: NCPDP ID number 3677955
Fax number: 800-345-8534
Phone number: 855-264-0104
Monday – Friday, 8 a.m. – 11 p.m., and
Saturday, 8 a.m. – 6:30 p.m., Eastern time

Date:_____

Patient information

Patient name: _____
Patient address: _____
_____
Patient Phone number: _____
Member ID: _____
Patient date of birth: _____
Allergies: ❑ No known allergies: _____
_____

Current weight: _____❑ lbs ❑ kg Height: _____

Primary diagnosis:

❑ Hemophilia type A factor VIII deficiency, D66
❑ Hemophilia type B factor IX deficiency, D67
❑ Hemophilia type C factor XI deficiency, D68.1
❑ von Willebrand disease, D68.0
❑ Other: _____

Clinical documents (please attach)

History and Physical (H and P) and progress notes within past six months

Severity: ❑ Mild ❑ Moderate ❑ Severe ❑ von Willebrand
Target joint(s): ❑ Yes ❑ No Location: _____
_____
Inhibitor: ❑ Yes ❑ No (Bethesda unit: _____)
Venous access: ❑ Peripheral ❑ Port
❑ PICC→ number of lumens:_____
Site of care: ❑ Patient's home ❑ Physician's office
❑ Outpatient infusion clinic: _____
Self-infused? ❑ Yes ❑ No

Pharmacy will dispense ancillary supplies as needed to establish IV and administer prescription drug.

Prescriber signature: _____
Prescriber name: _____
Prescriber address: _____
_____
DEA number: _____
NPI number: _____
Prescriber phone number: _____
Prescriber fax number: _____

Please provide supervising prescriber information (if applicable):

Prescriber name: _____
Prescriber address: _____
Prescriber phone number: _____
DEA number: _____
NPI number: _____

Note: If all information is not completed, the patient request will not be processed. We will contact your office for clarification.

Prescription information

❑ **ADVATE®**	❑ **ADYNOVATE®**	❑ **AFSTYLA®**
❑ **ALHEMO® PEN**	❑ **ALPHANATE®**	❑ **ALPHANINE® SD**
❑ **ALPROLIX®**	❑ **ALTUVIIIO®**	❑ **BENEFIX®**
❑ **ELOCTATE®**	❑ **FEIBA® VH**	❑ **FIBRYGA®**
❑ **HEMLIBRA®**	❑ **HUMATE-P®**	❑ **HYMPAVZI® PEN**
❑ **IDELVION®**	❑ **IXINITY®**	❑ **JIVI®**
❑ **KCENTRA®**	❑ **KOATE®**	❑ **KOVALTRY®**
❑ **NOVOEIGHT®**	❑ **NOVOSEVEN® RT**	❑ **PROFILNINE® SD**
❑ **REBINYN®**	❑ **RIXUBIS**	❑ **SEVENFACT®**
❑ **WILATE®**	❑ **XYNTHA®**	

❑ **Other: _____**

Prophylaxis dosing: _____
_____
Number of doses: _____ **Refill** for one year or _____
On-demand/as-needed dosing: _____
_____
Number of doses: _____ Refill for one year or _____

❑ *Normal saline 10 mL IV flush syringe* **Directions:** Use as directed to flush line with 10 mL before and after factor infusion and P.R.N. line care
Quantity: 28-day supply **Refill** for one year or _____

❑ *heparin 100 units/mL 5 mL prefilled syringe* **Directions:** Use as directed to flush line with 5 mL after final saline flush and P.R.N. line care
Quantity: 28-day supply **Refill** for one year or_____

Other therapies:

❑ *DDAVP 4 mcg/mL injection* **Directions:** _____
Quantity: _____ **Refills**: _____

❑ *Amicar® ❑ 500 mg tablets ❑ 1,000 mg tablets ❑ 250 mg/mL syrup*
Directions: _____
Quantity: _____ **Refills**: _____

❑ *Lysteda®* **Directions:** _____
Quantity: _____ **Refills**: _____

❑ *lidocaine/prilocaine cream 2.5%-2.5%:*
Directions: Apply topically to needle insertion site 30-60 minutes prior to needle insertion as directed.
Quantity: 30 grams **Refills**: _____

❑ **The skilled nursing visit will establish venous access, provide patient education related to therapy and disease state, administer medication as prescribed, and assess general status and response to therapy. Visit frequency is based on prescribed dosage orders.**

You can send this prescription electronically (eRx) by selecting "CenterWell Specialty Pharmacy" (National Council for Prescription Drug Programs ID number 3677955) from the list of pharmacies on your e-prescribing tool.