CenterWell Specialty Pharmacy

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

Hemophilia Prescription Request

Date: _____

Patient information

Patient name: _____
Patient address: _____
_____
Patient Telephone: _____
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&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 to dispense ancillary supplies as needed to establish IV and administer 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®**	❑**ALPHANATE®**
❑**ALPHANINE® SD**	❑**ALPROLIX®**	❑**BENEFIX®**	❑**ELOCTATE®**
❑**FEIBA® VH**	❑**HELIXATE®**	❑**HEMLIBRA®**	❑**HEMOFIL-M**
❑**HUMATE-P®**	❑**IDELVION®**	❑**IXINITY®**	❑**JIVI®**
❑**KCENTRA®**	❑**KOATE®**	❑**KOGENATE®**	❑**KOVALTRY®**
❑**NOVOEIGHT®**	❑**NOVOSEVEN® RT**	❑**PROFILNINE® SD**	❑**REBINYN®**
❑**RECOMBINATE™**	❑**RIXUBIS®**	❑**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**: _____

❑ *Stimate® nasal spray* **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**: _____

❑ **Skilled home infusion nursing visit to 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.