Hemophilia & Bleeding Disorders Enrollment Form

Date: ______________________________

☐ Current Patient ☐ New Patient

Century Specialty Script

Fax Referral To: 877-521-5353

Phone: 800-521-3949

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
☐ Advate ☐ Adynovate ☐ Alphanate ☐ Eloctate ☐ Helixate ☐ Hemofil-M ☐ Koate-DVI ☐ Kogenate FS ☐ Monoclate-P ☐ Nuwiq ☐ NovoEight ☐ Recombinate ☐ Xyntha	☐ Alphanine ☐ Alprolix ☐ Bebulin ☐ BeneFIX ☐ Ixinity ☐ Mononine ☐ Profilnine ☐ Rixubis ☐ Humate-P ☐ Wilate ☐ Feiba NF ☐ Novoseven RT	☐ ***Prophylaxis*** • Infuse _______________Units (+/-10%) slow iv-push every ____________________________________ ☐ ***Breakthrough Bleed*** • Infuse _______________Units (+/-10%) slow iv-push every ___________ hours/days (circle one) for a total of ___________ doses As Needed for bleeding episodes. Minor: ☐ ___________IU every ________hour/day PRN Major: ☐ ___________IU every ________hour/day PRN ☐ ***Other:*** __________________________________	☐ 1 month ☐ 3 month ☐ Specify _________	☐ 1 Year ☐ 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:** ________________________

If Century Specialty Script is the patient's choice, please Call-in, Fax, or Mail prescriptions to:
Century Specialty Script, 6 Fisher Avenue, Tuckahoe, NY, 10707 • Phone (800) 521-3949, Fax (877) 521-5353