Hemophilia

Prescription Referral Form Bushnell: Phone: 1.352.793.8000 Fax: 1.352.793.8007

Wildwood:Phone: 1.352.748.9900 Fax: 1.352.748.9902





www.safescript pharmacy.com

1. Patient Information												
Patient Name:				SSN:				D	ОВ:			
Address:						State:			Zip:			
Home Phone: Cell Phone			ne:		Email Address:							
Sex: ☐ Male ☐ Female Height:			Weight: ☐ lbs. ☐ kg. Know			wn Allerg	ies:					
2. Insurance	e Information:											
	Pl	ease fax front	and back c	opy of all Insura	ince cards (Prescr	iption ar	nd Medic	al)				
3. Diagnosis/Clinical Information:												
Please fax recent clinical notes, labs, and tests with the prescription to expedite the Prior Authorization												
Diagnosis: ICD 10:												
Nursing: Specialty Pharmacy to coordinate injection training/home health nurse visits as necessary? ☐ Yes ☐ No Site of care: ☐ MD office ☐ Infusion Clinic ☐ Outpatient Health ☐ Home Health												
4. Prescription Information: For IV medications attach a copy of your prescription												
Medication				Strength Dose & Directions				Quan	tity	Refills	1	
☐ Advate®	☐ Kogenate ^o	® FS □ Feiba	NF		☐ Prophylaxis: _							
☐ Adynova	•				☐ Immune Tolerance:							
			ate-P®		☐ Breakthrough Bleed: Infuse units (+/- 10%)				- 1			
☐ Alphanate® ☐ Novoeight® ☐ Von☐ Eloctate™ ☐ Nuwig® ☐ Will					slow IV push every hours / days (circle one) for a total of doses as needed for bleeding							
	- 1	□ Wilat	e®		episodes. Contact							
☐ Hemofil-		ate		IU/kg	bleeding does no		•					
☐ Koate® -	•				_							
☐ AlphaNir	ne® 🗌 IXINITY®	☐ Corifa	nct®		☐ Minor:				□ 1 n	no		
☐ Alprolix [®]			en®		☐ Other:				□ 3 n	no	☐ 1 year	
☐ Bebulin®		® □ Cepro	ntin		☐ Major:	IU a	hr PRN				•	
☐ BeneFIX®		-	nbate III®									
☐ Idelvion® ☐ Infombate III®			mg	☐ Other: mg slow IV push every hours,								
				and/or								
☐ Amicar® Tablet ☐ Amicar® Syrup			mg/kg									
Stimate®				☐ 150 mcg	Weight < 50kg: Si							
Name of Calin				☐ 300 mcg	Weight ≥ 50kg: Sin	ngle spray			<u>al)</u>			
Normal Salir	ie				□ Port □ PICC			every				
Heparin				☐ 10 IU/mL	☐ PIV ☐ Butt	<u> </u>	mL	every				
·				☐ 100 IU/mL	☐ Other:			<u>,</u>				
☐ Epi-Pen®		☐ Epi-Pen Jr.®			☐ PRN anaphylax	kis 🗆 O	ther:		_ 🗆 1 P			
									☐ 2 P	ens		
			7.01									╛
Ship to: ☐ Patient ☐ Office ☐ Other												
5. Physician Information:				Down with an AIDI				DEAU				
Prescriber Name: Address:			Prescriber NPI:			Ctoto	DEA#:		7in.			
Primary Office Contact:			City:		State	: one Number:		Zip:				
Office Contact Email:				rax Number.								
					riber, please sign and date b							
	ecipt of any required prior a	uthorization forms and	the receipt and su	ubmission of patient lab va	nitaite prior authorization pr alues and other patient data.	In the event	that this pharm	acy determines that it	t is unable to fu			,
further authorize to forward this information and any related to coverage of the product to another pharmacy of patient's choice or in the patient's insurer's provider network.												
☐ Dispense as written ☐ Substitution Permissible												
Prescriber's Signature				Date						_		
	Confidentiality Statement: This information which is exempt fro from disseminating or distributions.	message is intended only form om disclosure under applica uting this information (other	or the individual or e ble laws, including the r than to the intende	entity to which it is addressed. he Health Insurance Portability and recipient) or copying this in	It may contain information which y and Accountability Act (HIPAA). I formation. If you received this con	may be propried f you are not the nmunication in	etary and confident ne intended recipie error, please notif	tial. It may also contain prent, please note that you a y the sender immediately	ivileged, confider are strictly prohib at the address ar	ntial lited nd		
Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable leaves, including the Health insurance Portability and Accountability (Accountability (1) you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (tother than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately at the address and telephone number set forth herein and obtain instructions as to proper destruction of the transmitted material. Thank you. This prescription is valid only if transmitted by facsimile machine by a licensed prescriber.												
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