BLEEDING DISORDER DRUGS

FOR QUESTIONS, CALL 1.800.323.6832 | Fax all pages to (855) 270-7347

Patient Information

Order Date:	Requested Start of Care Date:	Date of birth :	
Patient name:	Height:	Weight: lb / kg	
Address:	City:	State:	Zip:

IV Access: ◯ Peripheral ◯ Port ◯ Other: _____ ◯ N/A

☐ D66 Hereditary Factor VIII Disorder (Hemophilia A); severity: ☐ mild ☐ moderate ☐ severe
☐ D67 Hereditary Factor IX Disorder (Hemophilia B); severity: ☐ mild ☐ moderate ☐ severe
☐ D68.0 Von Willebrand's Disease; type: ☐ 1 ☐ 2A ☐ 2B ☐ 2M ☐ 2N ☐ 3

☐ Other: ICD-10:

Allergies:	Circulating factor level:	Target factor level:

Bleeding Disorder Drug Orders (dispense size & quantity sufficient for month supply unless otherwise noted)

RX#	Brand	Dose	Units	Variance	Route	Directions (frequency) for use	# bleed doses to keep on hand
1			☐ I.U. ☐ RCoF	+/- 10% or _____ %	☐ IV ☐ SubQ		
2			☐ I.U. ☐ RCoF	+/- 10% or _____ %	☐ IV ☐ SubQ		
3			☐ I.U. ☐ RCoF	+/- 10% or _____ %	☐ IV ☐ SubQ		
4			☐ I.U. ☐ RCoF	+/- 10% or _____ %	☐ IV ☐ SubQ		

- Refill _____ months (Unless noted, prescriptions will be valid 1 year from date signed.

Other Drug Orders (dispense size & quantity sufficient for month supply unless otherwise noted)

- Refill _____ months (Unless noted, prescriptions will be valid 1 year from date signed.)

Other Orders (Dispense quantity sufficient)

Ancillary supplies as necessary to administer factor and other medications, including equipment, devices and disposables.

☐ Nursing needed: Nurse to administer medications per physician orders. If IV route: nurse to obtain IV access via placement of peripheral IV catheter or butterfly needle and instruct patient or caregiver IV access. If peripheral IV, may leave in place up to 5 days as long as no erythema or edema.

Physician Information

Signature:	Name:
	NPI#:
	Address:
Date:	Phone: Fax:

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