

Bleeding Disorder Drugs

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: <input type="radio"/> Peripheral <input type="radio"/> Port <input type="radio"/> Other: _____ <input type="radio"/> N/A			
<input type="checkbox"/> D66 Hereditary Factor VIII Disorder (Hemophilia A); severity: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe <input type="checkbox"/> D67 Hereditary Factor IX Disorder (Hemophilia B); severity: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe <input type="checkbox"/> D68.0 Von Willebrand's Disease; type: <input type="checkbox"/> 1 <input type="checkbox"/> 2A <input type="checkbox"/> 2B <input type="checkbox"/> 2M <input type="checkbox"/> 2N <input type="checkbox"/> 3 <input type="checkbox"/> 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			<input type="checkbox"/> I.U. <input type="checkbox"/> RCoF	+/- 10% or _____ %	<input type="checkbox"/> IV <input type="checkbox"/> SubQ		
2			<input type="checkbox"/> I.U. <input type="checkbox"/> RCoF	+/- 10% or _____ %	<input type="checkbox"/> IV <input type="checkbox"/> SubQ		
3			<input type="checkbox"/> I.U. <input type="checkbox"/> RCoF	+/- 10% or _____ %	<input type="checkbox"/> IV <input type="checkbox"/> SubQ		
4			<input type="checkbox"/> I.U. <input type="checkbox"/> RCoF	+/- 10% or _____ %	<input type="checkbox"/> IV <input type="checkbox"/> 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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