Hemophilia & Bleeding Disorders Enrollment Form

Date: _____

Hometech Advanced Therapies
Fax Referral To: 855-884-9283
Phone: 855-494-3121

HOMETECH ADVANCED THERAPIES

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:** _____