# Bleeding disorders referral form

**Infusion pharmacy**

Phone: _____

Fax: _____

✂ Please detach before submitting to a pharmacy – tear here.

## PATIENT INFORMATION Attach insurance card(s)

| | | | |
|---|---|---|---|
| **Optum Rep:** | | | Phone: |
| **Patient:** ☐ see attached Gender: ☐ Male ☐ Female | | | |
| Patient name: | | DOB: | SSN: |
| Address: | | | City: |
| State: | ZIP: | Phone: | Cell: |
| Emergency contact: | | Phone: | Relationship: |
| **Insurance:** ☐ Front and back of insurance card to follow | | | |
| Primary Insurance: | Phone: | Policy #: | Group: |
| Secondary Insurance: | Phone: | Policy #: | Group: |

**Physician orders:**

**Brand name:**

| | | | | |
|---|---|---|---|---|
| Prophylactic dose: | (+/- %) | Freq: | Qty: | Refills: |
| Bleed dose: | (+/- %) | Freq: | Qty: | Refills: |
| Bleed dose: | (+/- %) | Freq: | Qty: | Refills: |
| Bleed dose: | (+/- %) | Freq: | Qty: | Refills: |

**IV access:** ☐ PIV/Butterfly needle ☐ CVAD ☐ Implantable port

☑ Flush PIV with Sodium Chloride 0.9%: 5mLs pre- and post- infusion. If Port access: Sodium Chloride 0.9%, 10mls pre- and post-infusion followed by Heparin 100 units/mL, 5mLs as final lock for patency (for other orders, contact physician).

☑ Nursing to administer and teach prescribed medication and establish and/or maintain IV access device as required.

☑ Pharmacy to dispense needles, syringes, HME/DME in quantity sufficient to complete therapy as prescribed.

**Primary diagnosis:** (Please select a diagnosis and severity level, if appropriate)

| | |
|---|---|
| ☐ **D66:** Hereditary factor VIII ☐ Mild ☐ Moderate ☐ Severe | ☐ **D67**: Hereditary factor IX ☐ Mild ☐ Moderate ☐ Severe |
| ☐ **D68:** Hereditary deficiency of other clotting factors | ☐ **D68.1:** Von Willebrand's ☐ Mild ☐ Moderate ☐ Severe |
| ☐ **D68.2:** Hereditary factor XI deficiency ☐ Mild ☐ Moderate ☐ Severe | ☐ **D68.311:** Acquired hemophilia |
| ☐ **Other:** | |

**Patient has inhibitor?** ☐ Yes ☐ No If positive, ☐ > 5 BU or ☐ ≤ 5 BU ☐ or unknown

**Target Joints:**

☑ **Anaphylaxis kit order** Infusion Reaction Management x1 year

| | |
|---|---|
| **Mild** | Slow infusion rate by 50% until symptoms resolve. Resume at previous rate as tolerated.<br>☑ DiphenhydrAMINE PO ☐ 25mg ☐ 50mg ☐ mg Dispense diphenhydrAMINE 25mg capsules x 4 |
| **Moderate** | Stop Infusion, resume at 50% rate when symptoms resolve<br>☑ DiphenhydrAMINE IV ☐ 25mg ☐ 50mg ☐ mg Dispense diphenhydrAMINE 50mg vial x 1 |
| **Severe (Anaphylaxis) *Call 911* Notify prescribing physician** | Stop infusion and remove tubing from access device to prevent further administration<br>• Initiate 0.9% NaCl 500mL/hr IV OR mL/hr<br>• **Administer EPINEPHrine 1mg/mL by weight (Wt.) as an IM injection into the lateral thigh**<br>Wt > 66lbs (30kg) 0.3mg/0.3mL — Wt 33 to 66 lbs (15 to 30kg) 0.15mg/0.15mL — Wt < 33lbs (15kg) 0.01mg/kg<br>• Repeat EPINEPHrine in 5 to 15 minutes if symptoms persist<br>• Administer CPR if needed until EMS arrives<br>☐ Dispense EPINEPHrine x 2: ☐ 1mg vial ☐ Pen JR 0.15mg ☐ Pen 0.3mg ☐ Other: |

**This form is not a valid prescription in Arizona.**

*Page 1 of 2, continued on page 2*

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Patient name: _____ DOB:_____

| PHYSICIAN INFORMATION | | | | |
|---|---|---|---|---|
| Name: | | Practice: | | |
| Address: | | City: | State: | ZIP: |
| Phone: | Fax: | NPI: | Contact: | |
| By signing, I certify/recertify that the above therapy, products and services are medically necessary and that this patient is under my care. I have received authorization to release the above referenced information and medical and/or patient information relating to this therapy. Pharmacy has my permission to contact the insurance company on my behalf to obtain authorization for patient. | | | | |
| Please fax: ☐ Completed form ☐ Demographic sheet/insurance information ☐ Clinical notes and lab ☐ TB results | | | | |
| Signature: _____ Date: _____ | | | | |

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