

HEMOPHILIA CASE REVIEW FORM

Complete this form in its entirety and provide relevant progress notes and/or bleeding diaries. All information must be faxed to 1-888-656-0841.

I. Patient Information					
Name		Date of Birth		Contract Number	
II. Prescriber Information					
Name			National Provider Identifier (NPI)		
III. Patient Inventory					
Total Doses on Hand			Total Units on Hand		
IV. Clinical/Prescription Information					
Product Name					
Dose (IU) Requested by Prescriber		Dosing Frequency		Total Dose (IU) Requested	
Total Number of Doses To Dispense		Total Units Requested To Dispense		Retrospective Request <input type="checkbox"/> Yes <input type="checkbox"/> No	
Additional Instructions					
Type of Use <input type="checkbox"/> Acute Bleeding Episode <input type="checkbox"/> Dental Procedure: Date of Procedure _____ <input type="checkbox"/> Episodic <input type="checkbox"/> Prophylaxis <input type="checkbox"/> Surgical Prophylaxis: Date of Procedure _____			Place of Administration <input type="checkbox"/> Home Infusion <input type="checkbox"/> Outpatient Hemophilia Treatment Center (HTC) <input type="checkbox"/> Outpatient Hospital <input type="checkbox"/> Provider's Office <input type="checkbox"/> Self-administration		
V. Acute Bleeding Summary (if applicable since the last request)					
Bleeding					
Date of Bleed (Start)		Date of Bleed (End)		Type of Bleed <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	
Location of Bleed		Number of Doses Used		Total Units (IU) Used	
Bleeding 2					
Date of Bleed (Start)		Date of Bleed (End)		Type of Bleed <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	
Location of Bleed		Number of Doses Used		Total Units (IU) Used	
VI. Dispensing Information (based on specialty pharmacy dispensing)					
Type of Use <input type="checkbox"/> Acute Bleeding Episode <input type="checkbox"/> Dental Procedure <input type="checkbox"/> Episodic <input type="checkbox"/> Prophylaxis <input type="checkbox"/> Surgical Prophylaxis	Unit IU Per Dose	Vial Strength	Assay Available	Number of Vials Requested	Units Requested to Dispense
Type of Use <input type="checkbox"/> Acute Bleeding Episode <input type="checkbox"/> Dental Procedure <input type="checkbox"/> Episodic <input type="checkbox"/> Prophylaxis <input type="checkbox"/> Surgical Prophylaxis	Unit IU Per Dose	Vial Strength	Assay Available	Number of Vials Requested	Units Requested to Dispense
I attest that the assay(s) requested above are the closest available to the prescribed dose. (Signature Required)					