ASP CARES

Hemophilia & Bleeding Disorder

Ph: (214) 919-2090 or (877) 753-6878
Fax: 1 (888) 294-9434

MAIN POINT OF CONTACT
Name:____________________________
Phone:____________________________

Injection Training: ☐ MD Office ☐ Pharmacy to Arrange
Ship To : ☐ Patient Home ☐ MD Office

PATIENT INFORMATION (Use this area or attach patient demographics)

Name:____________________ Phone:____________________ Phone 2:____________________
Home Address:________________________________ City:__________ State:_____ Zip Code:____________
DOB:______________ SSN:__________________ Sex: ☐ Male ☐ Female Height:_________ Weight:__________lbs.
Emergency Contact:________________________________ Phone:________________________________

INSURANCE INFORMATION (Use this area or attach copy of insurance card(s))

Primary Insurance:____________________________ Secondary Insurance:____________________________
ID#:____________________ RxBin:__________________ ID#:____________________ RxBin:__________________
RxGroup:________________ Pcn:__________________ RxGroup:________________ Pcn:__________________

DIAGNOSIS (ICD-10) and Allergy:

☐ D66 Hereditary Factor VIII Deficiency
☐ D67 Hereditary Factor IX Deficiency
☐ D68.0 Von Willebrand's Disease
☐ D68.311 Acquired Hemophilia
☐ D68.318 Other Hemorrhagic Disorder due to Intrinsic Circulating Anticoagulants, Antibodies, or Inhibitors
☐ Other:________________ Description:____

Allergies:

Medication	Strength	Directions	Qty.	Refills
☐ Advate ☐ Kogenate FS ☐ Adynovate ☐ Kovaltry ☐ Afstyla ☐ Monoclate-P ☐ Alphanate ☐ Novoeight ☐ Elocatte ☐ Nuwiq ☐ Helixate ☐ Recombinate ☐ Hemofil-M ☐ Xyntha ☐ Koate-DVI ☐ AlphaNine ☐ IXINITY ☐ Alprolix ☐ Mononine ☐ Bebulin ☐ Profilnine ☐ BeneFIX ☐ Rixubis ☐ Idelvion ☐ Feiba NF ☐ Corifact ☐ Humate-P ☐ Tretten ☐ Vonvendi ☐ Ceprotin ☐ Wilate ☐ Thrombate III	_____IU/kg	☐ Prophylaxis:______________________________ ☐ Immune Tolerance:__________________________ ☐ Breakthrough Bleed: Infuse _____units (+/- 10%) slow IV push every _____ ☐ hours ☐ days for a total of _____doses as needed for bleeding episodes. Contact your physician's office if bleeding does not resolve. Minor: ☐ _____IU q_____ hr PRN ☐ Other:_____________ Major: ☐ _____IU q_____hr PRN ☐ Other:_____________	☐ 1 Month ☐ 3 Months ☐ ________	☐ 1 Year ☐ ________
☐ NovoSeven RT	_____mg	Infuse ______mg slow IV push every ______hours and/or______________________________		
☐ Amicar Tablet ☐ Amicar Syrup	_____mg/kg			
☐ Stimate	☐ 150 mcg ☐ 300 mcg	☐ Weight < 50kg: Single spray in one nostril ☐ Weight > 50kg: Single spray in BOTH nostrils		
☐ Normal Saline		______mL every______ — Access Device: ☐ Port ☐ PICC ☐ PIV ☐ Butterfly ☐ Other__________		
☐ Heparin	☐ 10 IU/mL ☐ 100 IU/mL	______mL every______		
☐ Epi-Pen ☐ Epi-Pen Jr.		☐ PRN Anaphylaxis ☐ Other:______________	☐ 1 Pen ☐ 2 Pens ☐ ____ Pens	

Prescriber Name:____________________________________ NPI#:____________________________
Address:________________________________ City:______________ State:_____ Zip Code:____________
Phone:________________________________ Fax:________________________________

***Prescriber Signature:____________________________________Date:________________**

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