

Ship to: Patient Physician Other (please specify): _____
All supplies, including syringes and needles, will be dispensed if needed.

Patient Information	Patient Name: _____
	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female DOB: _____ SSN: _____
	Address: _____
	City: _____ State: _____ Zip: _____
	Phone: _____ Alt Phone: _____
	Email: _____ Alternate Contact Info: _____

PLEASE ATTACH COPIES OF FRONT AND BACK OF PATIENT'S PRESCRIPTION INSURANCE CARDS AND MOST RECENT LABS

Clinical Information	Diagnosis (ICD-10): <input type="checkbox"/> D66 Hereditary Factor VIII Deficiency <input type="checkbox"/> D67 Hereditary Factor IX Deficiency <input type="checkbox"/> D68.0 Von Willebrand's Disease <input type="checkbox"/> D68.311 Acquired Hemophilia <input type="checkbox"/> D68.318 Other Hemorrhagic Disorder Due to Intrinsic circulating anticoagulants, antibodies, or inhibitors <input type="checkbox"/> D68.8 Other Specified Coagulation Defects <input type="checkbox"/> D68.9 Coagulation Defect, Unspecified <input type="checkbox"/> D68.2 Hereditary Deficiency of Other Clotting Factors <input type="checkbox"/> Other: _____	Venous Access: <input type="checkbox"/> Peripheral IV <input type="checkbox"/> Port-a-Cath <input type="checkbox"/> PICC <input type="checkbox"/> AV Fistula <input type="checkbox"/> Other: _____
	Nursing Services Required: Specialty pharmacy to coordinate injection or infusion training / home health infusion nurse visit necessary? <input type="checkbox"/> Yes <input type="checkbox"/> No Site of care: <input type="checkbox"/> MD Office <input type="checkbox"/> Infusion Clinic <input type="checkbox"/> Outpatient Health <input type="checkbox"/> Home Health Injection / Infusion necessary? <input type="checkbox"/> Yes <input type="checkbox"/> No. If no, date training occurred: _____ Reason: <input type="checkbox"/> MD Office training patient <input type="checkbox"/> Patient already independent <input type="checkbox"/> Referred by MD to alternate training	Patient Clinical Information: Height: _____ <input type="checkbox"/> in <input type="checkbox"/> cm Weight: _____ <input type="checkbox"/> lb <input type="checkbox"/> kg Allergies: _____ _____

Prescription Information	Medication	Strength	Dose and Directions	Quantity Refills
	<input type="checkbox"/> Advate <input type="checkbox"/> Jivi <input type="checkbox"/> Adynovate <input type="checkbox"/> Koate-DVI <input type="checkbox"/> Afstyla <input type="checkbox"/> Kogenate <input type="checkbox"/> Alphanate <input type="checkbox"/> Kovaltry <input type="checkbox"/> AlphaNine <input type="checkbox"/> Novoeight <input type="checkbox"/> Alprolix <input type="checkbox"/> Nuwiq <input type="checkbox"/> BeneFIX <input type="checkbox"/> Profilnine <input type="checkbox"/> Corifact <input type="checkbox"/> Rebinyn <input type="checkbox"/> Ceprotin <input type="checkbox"/> Recominate <input type="checkbox"/> Eloctate <input type="checkbox"/> Rixubis <input type="checkbox"/> Feiba NF <input type="checkbox"/> Thrombate III <input type="checkbox"/> Hemofil-M <input type="checkbox"/> Tretten <input type="checkbox"/> Humate-P <input type="checkbox"/> Vonvendi <input type="checkbox"/> Idelvion <input type="checkbox"/> Wilate <input type="checkbox"/> Ixinity <input type="checkbox"/> Xyntha	_____ IU/kg	<input type="checkbox"/> <u>Prophylaxis:</u> _____ <input type="checkbox"/> <u>Breakthrough bleed:</u> Infuse _____ units (+/-10) slow IV push every _____ <input type="checkbox"/> hour <input type="checkbox"/> days (select one) for a total of _____ doses PRN bleeding episodes. Contact your prescriber's office if bleeding does not resolve <u>Minor:</u> <input type="checkbox"/> _____ IU every _____ hour PRN <input type="checkbox"/> Other: _____ <u>Major:</u> <input type="checkbox"/> _____ IU every _____ hour PRN <input type="checkbox"/> Other: _____ <input type="checkbox"/> <u>Immune tolerance:</u> _____ _____	Quantity: <input type="checkbox"/> 1 month <input type="checkbox"/> Other: _____ Refills: _____

Prescription Information	Medication	Strength	Dose and Directions	Quantity Refills
	<input type="checkbox"/> Hemlibra	<input type="checkbox"/> 30mg/mL <input type="checkbox"/> 60mg/0.4mL <input type="checkbox"/> 105mg/0.7mL <input type="checkbox"/> 150mg/1mL	<input type="checkbox"/> Initial dose: 3mg/kg sub-Q once weekly for 4 weeks <input type="checkbox"/> Maintenance dose: Weight: _____kg <input type="checkbox"/> 1.5mg/kg sub-Q every week <input type="checkbox"/> 3mg/kg sub-Q every 2 weeks <input type="checkbox"/> 6mg/kg sub-Q every 4 weeks <input type="checkbox"/> Other: _____	Quantity: <input type="checkbox"/> 1 month <input type="checkbox"/> Other: _____ Refills: _____
	<input type="checkbox"/> NovoSeven RT	_____mcg/kg	Infuse _____ mcg/kg slow IV push every _____ hours, and/or _____ Weight: _____ kg	Quantity: <input type="checkbox"/> 1 month <input type="checkbox"/> Other: _____ Refills: _____
	<input type="checkbox"/> Other: _____	_____	_____	Qty: ____ RF: ____

Flush Orders	Flush Orders	Normal Saline 0.9%	Heparin 10u/mL	Heparin 100u/mL	Other
	Before factor dose	_____mL	_____mL	_____mL	_____mL
	After factor dose	_____mL	_____mL	_____mL	_____mL

Ancillary Medication Information	Medication	Strength/Dose	Dose and Directions	Quantity Refills
	<input type="checkbox"/> Amicar	_____	_____	Qty: ____ RF: ____
	<input type="checkbox"/> Emla Cream	_____	_____	Qty: ____ RF: ____
	<input type="checkbox"/> Stimate nasal spray	_____	_____	Qty: ____ RF: ____
	<input type="checkbox"/> DDAVP solution for injection	_____	_____	Qty: ____ RF: ____
	<input type="checkbox"/> Epinephrine Pen	<input type="checkbox"/> Adult <input type="checkbox"/> Junior	<input type="checkbox"/> Adult: 0.3mg for patients ≥ 30kg <input type="checkbox"/> Junior: 0.15mg for patients 15kg to 30kg Give IM/sub-Q PRN severe allergic reaction – call 911. May repeat in 5-15 minutes as needed.	Qty: 1 box RF: _____
<input type="checkbox"/> Other: _____	_____	_____	Qty: ____ RF: ____	

Supply Orders	Supplies	Directions/Notes	Size	Quantity Refills
	<input type="checkbox"/> Syringes	_____	_____ mL	Qty: ____ RF: ____
	<input type="checkbox"/> Administration set / Infusion line	_____	_____ gauge	Qty: ____ RF: ____
<input type="checkbox"/> Other: _____	_____	_____	Qty: ____ RF: ____	

PRIOR AUTHORIZATION

Prescriber Name: _____ NPI: _____ DEA: _____ LIC#: _____

Address: _____

City: _____ Zip: _____ Tel: _____ Fax: _____

Contact Person: _____ E-Mail: _____

PRESCRIBER SIGNATURE
(Prescriber, please sign and date below)

No stamps. Signature and date must be completed in prescriber's handwriting.
NY prescriptions must be submitted via e script.

I authorize Polaris Specialty Pharmacy and its representatives to act as an agent to initiate and execute prior authorization for the above patient in order to expedite the process, please provide chart notes and most recent labs.

Physician's Signature: _____ Dispense as written (DAW) Date: ____/____/____

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