



# HEMOPHILIA FACTORS - Patient Enrollment and Prescription Form

Complete form in its entirety and fax to number listed below

## 1 PATIENT INFORMATION

Last Name		First Name	Middle Initial
Date of Birth	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Medicaid ID #	
Allergies: <input type="checkbox"/> NKA or _____			
Street Address		City	
State	County	Zip Code	
Home Phone		Cell Phone	
Parent/Guardian		Day Telephone	Night Telephone
Emergency Contact		Relationship	Telephone

## 2 PRESCRIBER INFORMATION

Prescriber's Name		NPI Number	DEA Number
Telephone Number	Fax Number	Hospital/Clinic Name	
Street Address		City	
State	County	Zip Code	
Contact Person at Office		Prescriber Specialty	



**Fax Completed Form to:**  
**Fax Number: 800-218-3221**   
**Phone Number: 866-843-3604**

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## Department of Vermont Health Access PRESCRIPTION HEMOPHILIA FACTORS

Patient Diagnosis:	
<input type="checkbox"/> Hemophilia A – Factor VIII Disease	
<input type="checkbox"/> Hemophilia B – Factor IX Disease	
<input type="checkbox"/> von Willebrand Disease	
Patient Weight (kg):	Native Factor Level:
Product Name:	
Dose / Frequency Instructions:	
# of doses ordered: _____ Refills: _____ If doses of different units are ordered, specific number of doses of each	
Reason(s) for Use:	
<input type="checkbox"/> Prophylaxis only	<input type="checkbox"/> Episodic only
<input type="checkbox"/> Acute Bleeding Episode	<input type="checkbox"/> Prophylaxis and PRN
<input type="checkbox"/> Surgical Prophylaxis	<input type="checkbox"/> Dental Procedure
Recent bleed while on Prophylaxis:	
Date of bleed: ____/____/____	
Location of bleed: _____ Severity of bleed: _____	
# of Doses already administered prior to this order: _____ IU/Dose: _____	
Deliver product to: <input type="checkbox"/> Patient's home <input type="checkbox"/> MD office <input type="checkbox"/> Clinic	
<input type="checkbox"/> Needles/syringes: quantity sufficient for factor supply	
Prescriber's Signature: _____	Date: _____