



HEMOPHILIA FACTORS - Patient Enrollment and Prescription Form

Complete form in its entirety and fax to number listed below

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	

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

Department of Vermont Health Access PRESCRIPTION HEMOPHILIA FACTORS

Patient Diagnosis:

- Hemophilia A – Factor VIII Disease
- Hemophilia B – Factor IX Disease
- 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:

- Prophylaxis only
- Episodic only
- Acute Bleeding Episode
- Surgical Prophylaxis
- Prophylaxis and PRN
- 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: Patient's home MD office Clinic

Needles/syringes: quantity sufficient for factor supply

Prescriber's Signature: _____ Date: _____