

Bleeding disorders referral form



Optum Infusion Pharmacy Phone: 1-855-855-8754 Fax: 1-800-311-0185

✂ Please detach before submitting to a pharmacy - tear here.

Optum representative:

Phone:

Patient information see attached

Patient name: Gender: M F DOB: Last 4 of SSN:
Address: City: State: ZIP:
Phone: Cell:
Emergency contact: Phone: Relationship:
Insurance: Front and back of insurance cards to follow
Primary Insurance: Phone: Policy #: Group:
Secondary Insurance: Phone: Policy #: Group:

Physician orders:

Current patient need: Procedure scheduled for STAT/URGENT bleed Ongoing care, not an urgent request

Factor brand name:

Prophylactic dose:	(+/- %)	Freq:	Qty:	Refills:
Bleed dose:	(+/- %)	Freq:	Qty:	Refills:
Bleed dose:	(+/- %)	Freq:	Qty:	Refills:
Bleed dose:	(+/- %)	Freq:	Qty:	Refills:
Other Drug:	Dose:	Route:	Frequency:	Qty: Refills:
Other Drug:	Dose:	Route:	Frequency:	Qty: Refills:

IV access: PIV/Butterfly needle CVAD Implantable port

- Flush PIV with Sodium Chloride 0.9%: 5ml pre- and post- infusion. If Port access: Sodium Chloride 0.9%, 10ml pre- and post-infusion followed by Heparin 100 units/ml, 5ml as final lock for patency (for other orders, contact pharmacy).
 - Skilled nursing to administer/teach preparation, infusion, self-monitoring of prescribed medication and to establish/maintain IV access as required.
 - Pharmacy to dispense needles, syringes, flushes, HME/DME in quantity sufficient to complete therapy as prescribed.
- Anaphylaxis management** x1 year (Select check box to order.)

For Anaphylaxis

- Stop infusion and remove infusion set needle from body to prevent further administration of causative drug
 - **Administer contents of EPINEPHrine autoinjector (pen) as an IM injection into the lateral thigh**
 - Repeat EPINEPHrine in 5 to 15 minutes if symptoms persist
 - Administer CPR if needed until EMS arrive
 - Notify prescribing physician after EMS care is received and condition is stable
- Pharmacy to dispense weight (Wt) appropriate EPINEPHrine pen x 2, 0.3mg/0.3ml if Wt >66lbs (>30kg), 0.15mg/0.15ml if Wt 33 to 66lbs (15 to 30kg), 0.1mg/0.1ml if Wt <33lbs (<15kg).

Call 911

Clinical information:

Primary diagnosis: Please select a diagnosis and severity level, if appropriate

D66: Hereditary factor VIII Mild Moderate Severe

D67: Hereditary factor IX Mild Moderate Severe

D68: Hereditary deficiency of other clotting factors

D68.1: Von Willebrand Type1 Type2 Type3

D68.2: Hereditary factor XI deficiency Mild Moderate Severe

D68.311: Acquired hemophilia

Other:

Patient has inhibitor? Yes No If positive, >5 BU or ≤5 BU or unknown

Target Joints:

Physician information

Name: Practice:
Address: City: State: ZIP:
Phone: Fax: NPI: Contact:

By signing, I certify/recertify that the above therapy, products and services are medically necessary and that this patient is under my care. I have received authorization to release the above referenced information and medical and/or patient information relating to this therapy. Pharmacy has my permission to contact the insurance company on my behalf to obtain authorization for patient.

Signature: Date:

Please fax: Completed form Demographic sheet/insurance information Clinical notes and labs

This form is not a valid prescription in Arizona or New York.