

Patient Information

Patient Name: _____
 Date of Birth: _____ Sex: _____ SS# _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Home Phone: _____ Work Phone: _____
 Cell Phone: _____ E-mail: _____
 Please attach copy of front and back of patient's prescription ins. card(s) if applicable
 Insurance Company Name: _____
 Insurance Company Phone: _____
 Policy holder: _____
 Policy holder Employer: _____
 Relationship to Patient: _____
 Prescription Coverage ID# _____ Group# _____
 RxBIN: _____ RxPCN: _____

Prescriber Information

Hemophilia Treatment Center Affiliation: _____
 Patient's Coordinator Contact: _____
 Practice/Organization Name: _____
 Physician Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone#: _____ Fax#: _____
 DEA# _____ NPI# _____
 License#: _____ Medicaid UPIN#: _____
 Shipment Address: _____ Attn: _____
 City: _____ State: _____ Zip: _____

If shipped to the physician's office, physician accepts on behalf of patient for administration in office.

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, and proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee the recipient should immediately notify the sender at the address and telephone number set forth herein and obtains instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee by express authority of the sender to the named addressee. Orchard Pharmaceutical Services, Inc. 011413

Clinical Information and Prescription
Primary Diagnosis

☐ 286.0 Hemophilia A (Factor VIII deficiency) ☐ 286.1 Hemophilia B (Factor IX Deficiency)
☐ 286.2 Hemophilia C (Factor XI Deficiency) ☐ 286.4 von Willebrand disease; type ☐ 1 ☐ 2 ☐ 3
☐ Other: _____

Inhibitor Activity: ☐ None ☐ Historical ☐ Current: _____ B. U. **Bypassing Agent Use:** ☐ None ☐ Yes: _____

Severity: ☐ Mild (>5% Activity) ☐ Moderate (1-5% activity) ☐ Severe (<1% activity)

Target Joints? ☐ No ☐ Yes: _____

Patient Height: _____ Patient Weight: _____ Date Taken: _____ Allergies: _____

Current Medications: _____

Co-Morbidities: _____

Vascular Access: ☐ peripheral IV ☐ port-a-cath ☐ PICC ☐ central line ☐ other: _____

Infusion by: ☐ Patient ☐ Caregiver ☐ Nursing Agency: _____ ☐ Other: _____

Does Orchard need to coordinate nursing care? ☐ No ☐ Yes, preference: _____

Factor VIII

☐ Advate ☐ Helixate FS ☐ Recombinate ☐ Kogenate FS ☐ Wilate
☐ Xyntha ☐ Hemofil M ☐ Monarc M ☐ Monoclate P ☐ Koate DVI
☐ Alphanate ☐ Humate P

Factor IX

☐ Benefix ☐ Alphanine SDVF ☐ Mononine ☐ Bebulin ☐ Profilnine SD

Anti-Inhibitor Products:

☐ Feiba VH ☐ Novoseven RT ☐ Novoseven

Antithrombotic Factor

☐ Thrombate III

Other:

Stimate ☐ 150mcg (single spray) in one nostril ☐ 150mcg (single spray) in both nostrils QTY: _____

DDAVP ☐ 4mcg/ml ☐ 5mcg/ml Directions: _____ QTY: _____

Other: _____ QTY: _____

Protocol: ☐ Continuous Prophylaxis ☐ Immune tolerace ☐ Standard ☐ Pre-Surgical

Dosing Regimen	Prophylaxis	Minor bleed	Moderate Bleed	Severe Bleed
Dose in Units (mg for Factor VII)				
Number of Doses per month to dispense				

Flush Orders:

Before Factor: ☐ NaCl 0.9% (NS) _____ ml ☐ Heparin 10u/ml _____ ml ☐ Heparin 100u/ml _____ ml

After Factor: ☐ NaCl 0.9% (NS) _____ ml ☐ Heparin 10u/ml _____ ml ☐ Heparin 100u/ml _____ ml

Supplies requested: _____

Refills Authorized: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 6 mos ☐ 1 yr ☐ Other: _____

X _____

Physician Signature (no stamps)

Date