RE PHARMACY
PASSION FOR LIFE

866 413-3156 toll free phone
877 834-1231 toll free fax
QUESTIONS? Please contact us!
www.REPharmacy.com

Hemophilia Prescription Referral Form

Send your Rx to:

Select Location

Date Medication Needed: _____ Ship To: (○) Patient's Home (○) Prescriber's Office (○) Pick-up (store location): _____ Injection training by pharmacy? ☐

1. Patient Information | Insurance Information

Please include copies of the FRONT and BACK of ALL insurance cards (prescription and medical) with this fax.

Patient Name: _____ Birth Date: _____
Soc. Sec. #: _____ Preferred Phone: _____
Address: _____
Alternate Caregiver Name: _____
Insurance Provider: _____
ID #: _____ Policy Group #: _____ PCN#: _____
Phone: _____ (Please include copy of card)

Sex: (○) Male (○) Female Height: _____ Weight: _____ (○) lbs. (○) kg.
Known Allergies: _____
City: _____ State: _____ Zip: _____
Preferred Phone: _____
Patient is eligible for Medicare Prescription Card: (○) Yes (○) No
Carrier: _____ Policy group #: _____

2. Prescriber Information

Provider Name: _____ Specialty: _____
Address: _____
City, State, Zip: _____

DEA#: _____ NPI#: _____ Tax ID#: _____
Phone: _____ Fax: _____
Key Contact: _____ Phone: _____

3. Diagnosis/Clinical Information

Please FAX recent clinical notes, labs, tests, with the prescription to expedite the prior authorization.

Has patient been previously treated for this condition? (○) Yes (○) No **Is patient currently on therapy?** (○) Yes (○) No
Current Medications: _____
Will patient stop taking the above medication(s) before the new medication? (○) Yes (○) No **Diagnosis (ICD-10 code):** _____
Provided by: ☐ Doctor's Office ☐ Caregiver ☐ Patient **Training Required:** (○) Yes (○) No **Notes:** _____

4. Prescription Information

Anti-Inhibitor Coagulant Complex
☐ FEIBA Dose: _____ Sig: _____

Recombinant (Fc Fusion Protein)
☐ Eloctate (Biogen Idec) Dose: _____ Sig: _____

Recombinant (PEGylated)
☐ Adynovate Dose: _____ Sig: _____

Factor XIII A-Subunit (Recombinant)
☐ Tretten (Novo Nordisk) Dose: _____ Sig: _____

Factor IX
☐ AlphaNine SD ☐ Alprolix ☐ BeneFIX ☐ IDELVION ☐ Bebulin
☐ Profilnine ☐ Mononine ☐ RIXUBIS
Dose: _____ Sig: _____

Factor X (Human)
☐ COAGADEX Dose: _____ Sig: _____

Factor VIIa
☐ NovoSeven RT Dose: _____ Sig: _____

Factor XIII
☐ Corifact Dose: _____ Sig: _____

Von Willebrand Factor (Recombinant)
☐ Vonvendi Dose: _____ Sig: _____

Factor VIII; AHF
☐ Obizur ☐ Hemofil M ☐ Advate ☐ Helixate FS ☐ Kogenate FS
☐ Kovaltry ☐ Novoeight ☐ Nuwiq ☐ XYNTHA ☐ XYNTHA Solofuse
☐ AFSTYLA ☐ Recombinate Dose: _____ Sig: _____

5. Patient Support Programs

Please sign and date below to enroll in the pharmaceutical company assisted patient support program.

Patient Signature **Date**

6. Prescriber Signature

Prescriber, please sign and date below

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to RE Pharmacy to act as the prescriber's agent to begin and execute prior authorization process and to help patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Dispense as written **Date** **Substitution Permissible** **Date**

# of Prescriptions: _____

Faxed prescriptions will only be accepted from a prescribing practitioner. Prescribers are reminded patients may choose any pharmacy of their choice.