CSI PHARMACY
Clinical Specialty Infusions

Phone: (833) 569-1005 Fax: (430) 200-4889

Account Manager ______
Contact information ______

AZ: Please detach before submitting to a pharmacy.

Bleeding Disorder Enrollment Form

PATIENT INFORMATION

Please complete the following or send patient demographic sheet

Patient Name ______

DOB ______ Last Four of SS# ______ Gender ______

Address ______

Home Phone ______ Alternate phone ______

Legal Guardian name/phone ______

Language Preference ☐ English ☐ Spanish ☐ Other ______

Weight ______ lbs. Height ______ in.

Allergies ______

Current Medications ______

PRESCRIBER INFORMATION

Prescriber's Name ______

NPI ______ DEA ______

HTC/Group ______

Hospital Address ______

City, State, ZIP ______

Phone ______ Fax ______

Contact Person ______ Phone ______

INSURANCE INFORMATION (Must submit a copy of patient's insurance card including both sides)

Primary insurance name: ______ ID number: ______ BIN: ______ PCN: ______ Group: ______

Secondary insurance name: ______ ID number: ______ BIN: ______ PCN: ______ Group: ______

Prior Authorization Reference number ______

CLINICAL INFORMATION

Diagnosis — Please include diagnosis name with ICD-10 code

☐ D66 Hereditary factor VIII deficiency
☐ D67 Hereditary factor IX deficiency
☐ D68.24 Hereditary factor X deficiency
☐ Other Diagnosis: ICD-10 Code ______

Next Infusion Date ______ Access: ☐ Port ☐ PIV ☐ PICC Other: ______

Target Joints: ☐ No ☐ Yes ______

Protocol: ☐ Pre-Surgical ☐ Continuous Prophylaxis ☐ Immune Tolerance

Additional Information

Therapy: ☐ New ☐ Reauthorization ☐ Restart

Factor Deficiency: ☐ Severe (<1%) ☐ Moderate (1–5%) ☐ Mild (>5%)

History of inhibitor: ☐ No ☐ Yes

Tolerized? ☐ No ☐ Yes ☐ N/A

Nursing needed? ☐ No ☐ Yes Frequency of nursing ______

PRESCRIPTION INFORMATION

Medication

☐ Advate® ☐ Adynovate® ☐ Afstyla® ☐ Alphanate® ☐ AlphaNine® SD ☐ Alprolix® ☐ Benefix® ☐ Corifact® ☐ Eloctate®

☐ Esperoct ® ☐ Feiba® ☐ Helixate® FS ☐ Hemlibra® ☐ Hemofil M® ☐ Humate P® ☐ Idelvion® ☐ Ixinity® ☐ Jivi®

☐ Koate® ☐ Koate® DVI ☐ Kovaltry® ☐ Monoclate® P ☐ Mononine® ☐ NovoEight® ☐ NovoSeven® RT ☐ Nuwiq® ☐ Profilnine®

☐ Rebinyn ® ☐ Recombinate® ☐ Riastap® ☐ Rixubis® ☐ Sevenfact® ☐ Tretten® ☐ Vonvendi® ☐ Wilate® ☐ Xyntha®

☐ Xyntha® Solofuse ☐ Other

Dose / Strength*	Directions	Quantity	Refills

* Unless otherwise directed, pharmacy will dispense clotting factor within a range of +/- 10% of the prescribed dose, per MASAC guidelines.

Other Prescriptions	Dose / Strength	Directions	Quantity	Refills
☐ Sodium Chloride flushes	0.9%	Flush IV with 5 to 10 mL of 0.9% sodium chloride, pre and/or post infusion, as directed.		
☐ Heparin flushes				
☐ Epipen® or ☐ Epipen Jr.®		Inject as directed IM/SC if needed for anaphylaxis. May repeat in 5 to 15 minutes, if needed.	2	
☐ Lidocaine/Prilocaine topical cream	2.5%/2.5%	Apply topically to affected site 30 to 60 minutes prior to infusion.	30 grams	
☐ Amicar® tablet ☐ Amicar® solution				
☐ Lysteda®	650 mg tablets			
☐ Desmopressin nasal spray	150 mcg/actuation			

Ancillary supplies will be provided as needed for medication administration and disposal, unless otherwise noted:

Prescriber Authorization: I authorize the pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Ship to: Patient Office Other ______

Prescriber's Signature ______ Date ______ Needs by Date ______

Electronic or digital signatures not accepted.

Substitution is allowed unless the prescriber indicates "Brand Medically Necessary"

NY and IA providers, please submit electronic prescription for medication and needles, if needed.

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