Clinical Specialty Infusions, LLC

Phone: 833-569-1005 | Fax: 430-200-4889 | Online: deliver.myforcura.com

BLEEDING DISORDERS ENROLLMENT FORM

Account manager: **Contact info:**

✂ AZ: Please detach before submitting to a pharmacy.

PATIENT INFORMATION

Patient Name:		Legal guardian name/phone (if applicable):		
Address:		City:	State:	Zip:
Main phone:	Alternate phone:	Email:	Last 4 of SSN (required):	
Date of birth:	☐ Male or ☐ Female	Height (required): ☐ cm or ☐ inches	Weight (required):	☐ lb or ☐ kg
Language preference: ☐ English ☐ Spanish ☐ Other:		Current medications:		
Allergies:				

INSURANCE INFORMATION

Must include a copy of patient's insurance card(s), including both sides.

Primary insurance:	ID #:	BIN:	PCN:	Group #:
Secondary insurance:	ID #:	BIN:	PCN:	Group #:
Primary authorization reference #:				

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

ADDITIONAL INFORMATION

Next infusion date:	Access type: ☐ Port ☐ PIV ☐ PICC ☐ Other:	Treatment status: ☐ New ☐ Reauthorization ☐ Restart
Target joints? ☐ Yes ☐ No If Yes, describe:		History of inhibitor? Yes No If Yes, tolerized? Yes No
Protocol: ☐ Pre-surgical ☐ Continuous prophylaxis ☐ Immune tolerance		Nursing needed? ☐ Yes ☐ No If Yes, frequency:

PRESCRIPTION INFORMATION

☐ Advate	☐ Alprolix	☐ FEIBA	☐ Idelivion	☐ Mononine	☐ Profilnine	☐ Rixubis	☐ Wilate
☐ Adynovate	☐ Benefix	☐ Helixate FS	☐ Ixinity	☐ Novoeight	☐ Rebinyn	☐ Sevenfact	☐ Xyntha
☐ Afstyla	☐ Corifact	☐ Hemlibra	☐ Jivi	☐ NovoSeven	☐ Recombinate	☐ Tretten	☐ Xyntha Solofuse
☐ Alphanate	☐ Eloctate	☐ Hemofil M	☐ Koate	☐ Nuwiq	☐ RiaSTAP	☐ Vonvendi	☐ 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 min., 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 INFORMATION

Physician name:	Practice site name:		
Address:	City:	State:	Zip:
NPI:	Phone:	Fax:	

Office contact and special instructions:

* **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.

Prescriber's signature: Date:

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