

BLEEDING DISORDERS ENROLLMENT FORM



Fax referral to: (844)469-5933
 Email referral to: Pharmacy@mylyfe.health
 Phone: (844)-4MYLYFE (695933)

Patient Information (Please complete or attach a demographic page)

Patient name: _____ DOB: _____
 Address: _____ City, ST, Zip : _____
 Sex: Male Female Language: _____
 Preferred Contact Method: Phone: _____ Text: _____ Email: _____
 Height: _____ cm in Weight: _____ kg lbs Allergies: _____

Prescriber Information

Prescriber name: _____ NPI: _____ DEA: _____
 Address: _____ City,ST,Zip: _____ Contact name: _____
 Phone: _____ Fax: _____ Email: _____

Insurance Information (Please email or fax a copy of front and back of all insurance cards)

Primary Plan: _____ Plan ID: _____ Policy Holder: _____ Relationship to Patient: _____
 Secondary Plan: _____ Plan ID: _____ Policy Holder: _____ Relationship to Patient: _____

Clinical Information

Diagnosis Code: D66 Hereditary Factor VIII deficiency Severity: _____ D67 Hereditary factor IX deficiency
 D68.0 Von Willebrand's disease D68.311 Acquired hemophilia
 D68.2 Hereditary deficiency of other clotting factors Other code: _____ Description: _____
 Current Medications: _____
 Comorbidities: _____

Prescription

Factor VIII	Advate® Kogenate® FS	Adynovate® Kovaltry®	Afstyla® Novoeight®	Eloctate® Nuwiq®	Esperoct® Recombinate®	Hemofil® M Xyntha®	Jivi®
Factor IX	AlphaNine® SD Rebinyn®	Alprolix® Rixubis®	BeneFix® RT	Idelvion®	Ixinity®	Mononine®	Profilnine® SD
Factor VIII + VWF VWF	Alphanate® SD	Humate-P®	Koate® DVI	Vonvendi®	Wilate®		
Factor X,XIII, AI, PTC	Coagadex®	Corifact®	Feiba®	Tretten®			
Factor VIIa	Novoseven® Sevenfact®	Dose: _____ Directions: _____ Number of doses: _____	Number of Refills: _____				
Factor X Activator	Hemlibra®	Initial dose: 3mg/kg subcutaneously once weekly for 4 weeks Maintenance dose: _____mg/kg subcutaneously every ___ week(s) Number of doses: _____ Number of Refills: _____					
Dose and Directions	<p>Prophylaxis Target dose: _____ IU/kg; Infuse _____ Units(+/- ____%) every ____ days Number of doses: _____ Number of refills: _____</p> <p>Breakthrough Bleed For minor bleeds: Infuse _____ units (=/- ____%) every _____ hours for ____ days For moderate bleeds: Infuse _____ units (=/- ____%) every _____ hours for ____ days For major bleeds: Infuse _____ units (=/- ____%) every _____ hours for ____ days Number of doses: _____ Number of refills: _____</p>						
Ancillary Supplies	As needed for proper administration and disposal of all medications and supplies						
Flushing Protocol	Heparin _____ units/mL Directions: _____ 0.9% Sodium Chloride 5-10mL Pre and post medication administration						
Other Medications	Amicar® Directions: _____	Lysteda®	Stimate®	Emla®	Other: _____ Qty: _____	Refills: _____	

"Interchange is mandated unless the practitioner indicates 'no substitution' in accordance with the law": _____

Prescriber's Signature: _____ **Date:** _____

I authorize Mylyfe and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to Mylyfe Pharmacy. IMPORTANT: This transmission contains confidential information, which may be protected health information as defined by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. This transmission is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential, and/or exempt from disclosure under applicable law. If you are not the intended recipient (or an employee or agent responsible for delivering this facsimile transmission to the intended recipient), you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by telephone (844)469-5933 to arrange the return or destruction of the information and all copies.