BLEEDING DISORDERS ENROLLMENT FORM

MYLYFE SPECIALTY PHARMACY

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® ☐ Adynovate® ☐ Afstyla® ☐ Eloctate® ☐ Esperoct® ☐ Hemofil® M ☐ Jivi® ☐ Kogenate® FS ☐ Kovaltry® ☐ Novoeight® ☐ Nuwiq® ☐ Recombinate® ☐ Xyntha®
Factor IX	☐ AlphaNine® SD ☐ Alprolix® ☐ BeneFix® RT ☐ Idelvion® ☐ Ixinity® ☐ Mononine® ☐ Profilnine® SD ☐ Rebinyn® ☐ Rixubis®
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	☐ **Prophylaxis** Target dose: _____IU/kg: Infuse _____Units(+/- _____%) every ____ days Number of doses: _____ Number of refills: _____ ☐ **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: _____
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® ☐ Lysteda® ☐ Stimate® ☐ Emla® ☐ Other: _____ Directions: _____ Qty: _____ Refills: _____

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

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