metroplex vitalcare
INFUSION SERVICES

Infusion Pharmacy Order Form
HEMOPHILIA/BLEEDING DISORDER
12700 Hillcrest Rd Suite 218, Dallas, TX 75230
Phone: 214-227-7645 | Fax: 214-227-2310
Email: intake@metroplexvitalcare.com

PATIENT INFORMATION

Name:_____ Phone: _____

Home Address: _____ City: _____ State: _____ Zip: _____

DOB: _____SSN: _____ Sex: ☐ Female ☐ Male Height: _____ Weight: _____

Emergency Contact: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____ Secondary Insurance: _____

ID#:_____RxBin: _____ ID#:_____RxBin: _____

RxGroup: _____ Pcn: _____ RxGroup: _____ Pcn:_____

DIAGNOSIS (ICD-10

☐ D66 Hereditary Factor VIII Deficiency
☐ D67 Hereditary Factor IX Deficiency
☐ D68.0 Von Willebrand's Disease
☐ D68.311 Acquired Hemophilia
☐ D68.318 Other Hemorrhagic Disorder due to Intrinsic Circulating Anticoagulants, Antibodies, or Inhibitors
☐ Other: _____

Allergies:

Access Device:
☐ Port ☐ PICC
☐ PIV ☐ Butterfly
☐ Other_____

MEDICATION STRENGTH

☐ Advate
☐ Adynovate
☐ Afstyla
☐ Alphanate
☐ AlphaNine
☐ Alprolix
☐ BeneFIX
☐ Corifact
☐ Elocatte
☐ Feiba NF
☐ Hemlibra
☐ Hemofil-M
☐ Humate-P
☐ Idelvion
☐ IXINITY
☐ Jivi
☐ Kcentra
☐ Koate-DVI
☐ Kogenate FS
☐ Kovaltry
☐ Mononine
☐ Nuwiq
☐ Rebinyn
☐ Recombinate
☐ Riastap
☐ Rixubis
☐ Thrombate
☐ Tretten
☐ Vonvendi
☐ Wilate
☐ Xyntha
☐

_____IU/kg

☐ Prophylaxis: _____
☐ Immune Tolerance: _____
☐ Breakthrough Bleed: Infuse_____units (+/-10%) slow IV push every _____ ☐ hours ☐ days for a total of _____doses as needed for bleeding episodes.

Contact your physician's office if bleeding does not resolve.

Minor: ☐ _____IU q _____hr PRN
☐ Other: _____

Major: ☐ _____IU q _____hr PRN
☐ Other: _____

☐ Stimate: ☐ 150mcg ☐ 300mcg ☐ Weight <50kg: Single spray in one nostril ☐ Weight >50kg: Single spray in BOTH nostrils

☐ Normal Saline: _____mL every _____

☐ Heparin: ☐ 10 IU/mL _____mL every_____ ☐ 100 IU/mL _____mL every _____

☐ Epi-Pen ☐ Epi-Pen Jr. ☐ PRN Anaphylaxis ☐ Other: _____

Physician Name/Signature:_____ Date:_____

Provider NPI: _____