

HEMOPHILIA AND RELATED BLEEDING DISORDERS
TELEPHONE 1-866-792-2731 FAX 1-866-811-7450

STATEMENT OF MEDICAL NECESSITY

1. PATIENT INFORMATION *To be completed by the patient*

Last Name		First Name		M.I.
Street Address				
City		State	ZIP	
Day Telephone # (+Area Code)		Night Telephone # (+Area Code)		Mobile Telephone # (+Area Code)
Date of Birth (MM/DD/YYYY)		Social Security #		Sex (Check One) <input type="checkbox"/> M <input type="checkbox"/> F
Parent/Guardian Name				

INSURANCE INFORMATION

Primary/Medical Insurance		Secondary/Pharmacy Insurance		
Cardholder Name & ID # (If Not Patient)		Cardholder Name & ID # (If Not Patient)		
Group/Policy #		Group/Policy #		
Insurance Telephone # (+Area Code)		Insurance Telephone # (+Area Code)		
Employer		Medicaid #		

ALTERNATE SHIPPING ADDRESS

Last Name		First Name		M.I.
Street Address				
City		State	ZIP	

Caremark is committed to protecting the privacy of your health information. We will hold your health information in confidence and will only use and disclose it in accordance with applicable law.

2. PHYSICIAN INFORMATION *To be completed by the physician and staff*

Prescriber's Last Name		Prescriber's First Name		
Hospital/Clinic		Office Contact		
Street Address				
City		State	ZIP	
Telephone # (+Area Code)		Fax # (+Area Code)		E-Mail Address
Prescriber's License #		DEA #	NPI #	
UPIN#		Medicaid License #		

PRIMARY DIAGNOSIS:

<input type="checkbox"/> 286.0 Hemophilia A (Factor VIII Deficiency)	<input type="checkbox"/> 286.1 Hemophilia B (Factor IX deficiency)
<input type="checkbox"/> 286.2 Hemophilia C (Factor XI Deficiency)	<input type="checkbox"/> 286.3 Other Clotting Disorder
<input type="checkbox"/> 286.4 von Willebrand Disease	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
<input type="checkbox"/> 286.5 Hemorrhagic Disorders	<input type="checkbox"/> 286.7 Acquired Coagulation
<input type="checkbox"/> 286.9 Other Coagulation	<input type="checkbox"/> Other _____

Severe (<1% Activity) Moderate (1-5% Activity) Mild (>5% Activity) Circulating Factor _____%
 Inhibitor No Historical Current
 Date of Last Test / /
 Historical Response Hi Lo
 Weight _____ kg lbs
 Height _____
 Allergies _____

PERTINENT MEDICAL/BLEEDING HISTORY:

Target Joints No Yes Explain _____
 Protocols 1° Prophylaxis 2° Prophylaxis Preventative
 Immune Tolerance _____ Other _____
 Start Date / / End Date / /
 Trained For Home Infusion? No Yes
 Infusion Done By Parent Patient Other _____
 If No, Caremark to Refer/Coordinate With Nursing Agency? No Yes _____
 IV Access Method Peripheral Central Line Type _____
 CarePatterns? No Yes

Rx

Hemophilia Product

Target Dose (IU)
 Minor Major
 Prophylaxis Other

Flushing Protocol _____
 Other Instructions _____
 Deliver Product To Patient's Home Other

Ancillary Supplies and Kits Provided as Needed for Administration.

Dispense As Written Substitution Allowed

Prescriber's Signature	Date

3. FAX COMPLETED FORM TOLL-FREE TO THE HEMOPHILIA CARE PROGRAM @ 1-866-811-7450

Please include copies of the patient's insurance cards (front & back) when faxing the referral to expedite benefit clearance.
Thank you for choosing Caremark!