Mercy LTC & Specialty Pharmacy
A Member of Mercy Pharmacy Group

FAX: 562.402.4629

Hemophilia & Bleeding Disorders

Version: 9/26/2025

PATIENT INFORMATION

Patient Name	Date of Birth	○ Male ○ Female
Email	Last four of SS#	Main Phone
Address	City, State, Zip Code	

INSURANCE INFORMATION (Please fax a copy of patient's insurance card - both sides)

Prior Authorization Reference Number

CLINICAL INFORMATION

Diagnosis - Please include diagnosis name with ICD-10 code
- ○ D66 Hereditary factor VIII deficiency
- ○ D67 Hereditary factor IX deficiency
- ○ D67 Hereditary factor IX deficiency
- ○ D68.0 Von Willebrand Disease----- ○ Type 1 ○ Type 2 ○ Type 3
- ○ Other: ICD-10 Code _____ Description _____

Date of Diagnosis _____
Next Infusion Date_____ Target Joints: ○ No ○ Yes _____
Infusion by*: ○ Parent ○ Patient ○ Other _____
Access: ○ Peripheral ○ PICC ○ PORT ○ Other_____

Therapy: ○ New ○ Reauthorization ○ Restart
Weight: _____ kg/lb (circle) Height: _____ cm/in (circle)
Allergies: ○ NKDA ○ Other_____
Historical Response: ○ High ○ Low Date: _____
Factor Deficiency: ○ Severe (<1%) ○ Moderate (1-5%) ○ Mild (>5%)
Circulating Factor: _____ % Inhibitor: ○ Low ○ Historical ○ Current
Comorbidities: _____
Concomitant medications: _____

*Skilled nursing visits provided as needed

PRESCRIPTION INFORMATION (Ancillary supplies provided as needed for administration)

MEDICATION	DOSE & DIRECTIONS (dose to be +/-10% unless specified)	QUANTITY	REFILLS
Factor VIII (Recombinant) ○ Advate® ○ Eloctate® ○ Kogenate FS® ○ Nuwiq® ○ Adynovate® ○ Esperoct® ○ Kovaltry® ○ Recombinate® ○ Afstyla® ○ Jivi® ○ Novoeight® ○ Xyntha®	Assay Variation: +/-____%		
Factor VIII (Human) ○ Hemofil M® ○ Koate®	○ Prophilaxis: _____ ○ Immune Tolerance: _____	_____Doses/month _____Doses/month	_____ _____
Factor VIII and VWF *Dose will be dispensed in vWF:RCo units unless specified otherwise ○ Alphanate® ○ Humate P®** ○ Vonvendi®** ○ Wilate®**	○ Breakthrough Bleeding: ○ Minor: _____ ○ Moderate: _____ ○ Major: _____	_____Doses/month _____Doses/month _____Doses/month	_____ _____ _____
Factor IX ○ AlphaNine® SD ○ Benefix® ○ Ixinity® ○ Rebinyn® ○ Alprolix® ○ Idelvion® ○ Mononine® ○ Rixubis®	○ Other: _____	_____Doses/month	_____
Factor XIII ○ Corifact® ○ Tretten®			
Inhibitor Therapies, Factor VIIa, and other ○ Feiba® ○ NovoSeven® ○ Other:			
Hemlibra® ○ 30mg/mL ○ 60mg/0.4mL ○ 105mg/0.7mL ○ 150mg/mL	○ Initial dose: 3mg/kg subQ once weekly for 4 weeks ○ Maintenance dose: 1.5mg/kg subQ once weekly ○ Maintenance dose: 3mg/kg subQ every 2 weeks ○ Maintenance dose: 6mg/kg subQ every 4 weeks ○ Other: _____		
○ EMLA® Cream, 30gm ○ Other:			
○ EPIPEN® 0.3mg ○ EPIPEN Jr® 0.15mg	○ Inject as needed for anaphylaxis		
Stimate® ○ 150mcg / actuation nasal spray	○ Wt<50kg, single spray in one nostril (1 spray total) ○ Wt>50kg, single spray in each nostril (2 sprays total)		
Amicar® ○ 500mg tablets ○ 25% Oral Solution			
Lysteda® ○ 650mg tablets			
Flushing			
○ 0.9% Normal Saline Flush, 5-10ml pre and post IV medication administration		○ Quantity Sufficient	○ PRN
○ Heparin 10units/ml Flush, 3-5mls as needed ○ Heparin 1 OOunits/ ml Flush, 1-3mls as needed		○	○
Deliver to: ○ Patient ○ Office ○ Other	Needs by date		

PHYSICIAN INFORMATION

Physician Name	DEA #	NPI #	License #
Address	City, State, Zip Code		
Phone / Fax	Group/Hospital	Office Contact	

*Prescriber Authorization: I authorize this 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 (no stamps) | Substitution Permitted | Date | Prescriber's Signature | Dispense as Written | Date