Hemophilia & Clotting Disorder

Provider Order Form *rev. 1/2/2025*

AMERICAN INFUSION CARE
SPECIALTY INFUSION

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Full Name: _____ DOB:_____ Phone: _____ Gender: ☐ M ☐ F ☐ Other

Email Address: _____ Address: _____ Weight (lbs/kg): _____ Height (in): _____

NKDA Allergies: _____ Existing prior authorization? ☐ Yes, (Send a copy) ☐ No (AIC will process)

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

ICD 10-Code & Description (Provide full completed code)

- ☐ D66 Type A: Hereditary factor VIII deficiency
- ☐ D67 Type B: Hereditary factor IX deficiency
- ☐ D68.0 Von Willebrand's disease
- ☐ D68.1 Type C: Factor XI deficiency
- ☐ D68.2 Hereditary deficiency of other clotting factors
- ☐ D68.311 Acquired Hemophilia
- ☐ D68.4 Acquired coagulation factor deficiency
- ☐ D68.8 Other specified coagulation defects
- ☐ D68.9 Coagulation defect, unspecified
- ☐ Other: _____

REQUIRED DOCUMENTATION: Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results (CBC, CMP, TB, Hep B panel-depending on medication) , signed prescription order and recent visit notes.
☐ Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

PRESCRIPTION INFORMATION

Nursing: Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation
*other medication patients currently taking including OTC medications with dosage and direction: _____

Pre-Medications

- Acetaminophen (Tylenol) ☐500mg ☐650mg ☐ 1000mgPO
- Cetirizine (Zyrtec) 10mgPO
- Loratadine (Claritin) 10mgPO
- Diphenhydramine (Benadryl) ☐25mg ☐50mg ☐PO ☐IV
- Methylprednisolone (Solu-Medrol) ☐40mg ☐125mg IV
- Other: _____ Dose: _____ Route: _____

Lab Orders

Required: Negative TB results
☐ Other: _____

Medications (Select one):

- ☐ Advate
- ☐ Adynovate
- ☐ Afystla
- ☐ Alphanate
- ☐ AlphaNine
- ☐ Alprolix
- ☐ BeneFIX
- ☐ Corifact
- ☐ Eloctate
- ☐ Hemofil M
- ☐ Humate-P
- ☐ Idelvion
- ☐ Ixinity
- ☐ Vonvendi
- ☐ Wilate
- ☐ Xyntha

Strength: _____ IU/kg
☐ **Prophylactic Dosing:** Dose: _____ Frequency: _____ Refills:_____
☐ **Episodic Dosing:** Bleeding Dose: _____

- ☐ Dispense 30-day supply based on frequency
- ☐ Dispense _____ doses for a 30-day supply
- ☐ Other: _____

(Prescription valid for one year, unless otherwise indicated)

Flushing Protocol:

- ☐ 0.9% sodium chloride 5-10 mL pre/post infusion and PRN
- ☐ Heparin 10 units/mL post infusion and PR
- ☐ Heparin 100 units/mL post infusion and PR
- ☐ Other: _____

Post Treatment Observations: The patient is required to stay for 30 minutes following the first administration.
Special Instructions: _____

PROVIDER INFORMATION

Provider Full Name: _____ Provider NPI #: _____ Specialty: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____

_____ _____ _____
Provider Name (Print) *Provider Signature* *Date*

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McAllen F: 956.302.8906 P: 832.800.3213 Plano: F: 214.831.9829 P: 972.865.4454
Harlingen F: 956.341.9687 P: 832.800.3213 Laredo F: 956.306.3715 P: 832.800.3213
Other Locations (Oaklawn, Lancaster, etc): F: 469.305.2361 P: 972.865.4454