briovaRx®

Fax: 800-311-0185
Phone: 855-855-8754

Hemophilia & Related Bleeding Disorders Enrollment Form

PATIENT INFORMATION

*Please complete the following or **send patient demographic sheet***

Patient Name _____

DOB _____ Last Four of SS# _____

Gender _____

Address _____

City, State, ZIP _____

Home Phone _____

Alternate Phone _____

Language Preference: ☐ English ☐ Spanish ☐ Other _____

PRESCRIBER INFORMATION

Prescriber's Name _____

NPI _____ DEA _____

HTC/Group/Hospital _____

Address _____

City, State, ZIP _____

Phone _____ Fax _____

Contact Person _____ Phone _____

INSURANCE INFORMATION *(Must fax a copy of patient's insurance card including both sides)*

Prior Authorization Reference number _____

MEDICAL INFORMATION *(Section must be completed to process prescription)* *(Attach separate sheet if needed)*

Diagnosis — *Please include diagnosis name with ICD-10 code*

☐ D66 Hereditary factor VIII deficiency ☐ D67 Hereditary factor IX deficiency

☐ D68.1 Hereditary factor XI deficiency

☐ Other Diagnosis: ICD-10 Code _____

Description _____

Date of Diagnosis _____

Start Date _____ **End Date** _____

Next Infusion Date _____ **Target Joints:** ☐ No ☐ Yes _____

Infusion by: ☐ Parent ☐ Patient ☐ Other _____

Protocol:

☐ Standard ☐ Pre-Surgical ☐ Continuous Prophylaxis ☐ Immune Tolerance

Additional Information

Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight _____ kg/lbs Height _____ cm/in

Allergies _____

Circulating Factor ____ % Inhibitor: ☐ No ☐ Historical ☐ Current

Historical Response: ☐ High ☐ Low Date _____

Concomitant Medications _____

Factor Deficiency: ☐ Severe (<1%) ☐ Moderate (1–5%) ☐ Mild (>5%)

PRESCRIPTION INFORMATION *(If patient resides in New York, a prescription is required for needles)*

Medication

☐ Advate® ☐ Adynovate® ☐ Afstyla® ☐ Alphanate® ☐ AlphaNine® SD ☐ Alprolix® ☐ Bebulin® ☐ Benefix® ☐ Corifact®

☐ Eloctate® ☐ Feiba® ☐ Helixate® FS ☐ Hemlibra® ☐ Hemofil M® ☐ Humate P® ☐ IDELVION® ☐ Ixinity® ☐ Jivi®

☐ Koate® ☐ Koate® DVI ☐ Kogenate® FS ☐ Kovaltry® ☐ Monoclate® P ☐ Mononine® ☐ NovoEight® ☐ NovoSeven® RT ☐ Nuwiq®

☐ Profilnine® ☐ Recombinate® ☐ Riastap® ☐ Rixubis® ☐ Tretten® ☐ Vonvendi® ☐ Wilate® ☐ Xyntha®

☐ Xyntha® Solofuse ☐ Other

Dose / Strength	Directions	Quantity	Refills

Other Medications	Dose / Strength	Directions	Quantity	Refills
☐ Heparin				
☐ EMLA				
☐ Ancillary Supplies				

***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.

Ship to: ☐ Patient ☐ Office ☐ Other _____ Date _____ Needs by Date _____

☐ Product Substitution permitted ☐ Dispense as Written

Prescriber's Signature _____ Date _____