



Hematology Patient Demographics Form

816 N. 6th Ave.
 Phoenix, AZ 85003
 Phone: (844) 482-2005
 Fax: (833) 437-2301

| PATIENT INFORMATION | PRESCRIBER INFORMATION |
|---|-----------------------------------|
| Patient Name: _____ | Prescriber Name: _____ |
| Address: _____ | State License: _____ NPI #: _____ |
| City, State, Zip: _____ | DEA: _____ |
| Phone: _____ Alt. Phone: _____ | Phone: _____ Fax: _____ |
| DOB: _____ Last 4 SSN: _____ | Address: _____ |
| Gender: M F Height: _____ Weight: _____ | City, State, Zip: _____ |
| Allergies: _____ | Office Contact: _____ |

INSURANCE INFORMATION - May also scan front and back of insurance card and attach to form

| | |
|--------------------------|----------------------------|
| Primary Insurance: _____ | Rx Card (PBM): _____ |
| Member ID #: _____ | BIN: _____ PCN: _____ |
| Plan # _____ | Group #: _____ |
| Group #: _____ | Phone: _____ |
| Phone: _____ | Subscriber Name/DOB: _____ |

DIAGNOSIS / CLINICAL INFORMATION - Please attach recent clinical notes and labs with this form

| | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> D66 Hereditary factor VIII deficiency (hemophilia A) | <input type="checkbox"/> D68.311 Acquired hemophilia | <input type="checkbox"/> Other Code: |
| <input type="checkbox"/> D67 Hereditary factor IX deficiency (hemophilia B) | <input type="checkbox"/> D68.4 Acquired coagulation factor deficiency | |
| <input type="checkbox"/> D68.1 Hereditary factor XI deficiency (hemophilia C) | <input type="checkbox"/> D68.59 Other primary thrombophilia | |
| <input type="checkbox"/> D68.0 von Willebrand's disease Type: | <input type="checkbox"/> D59.3 Hemolytic-uremic syndrome | |
| <input type="checkbox"/> D59.5 Paroxysmal nocturnal hemoglobinuria | <input type="checkbox"/> D59.5 Paroxysmal nocturnal hemoglobinuria | |
| Severity: <input type="checkbox"/> MILD <input type="checkbox"/> MODERATE <input type="checkbox"/> SEVERE Target Joint: _____ Inhibitors: <input type="checkbox"/> YES <input type="checkbox"/> NO | | |

PRESCRIPTION - PLEASE ATTACH COPY OF SIGNED PRESCRIPTION WITH THIS FORM

Please include the following information on prescription:

- Biologic product and unit dose
- Directions for administration
- Number of doses to dispense/month and refills (if applicable)
- Patient's flush requirements

ADMINISTRATION

| Nursing | Route | Delivery | |
|---|--|------------------------|--|
| <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> Peripheral <input type="checkbox"/> Port | Patient Needs Dose by: | Ship to: <input type="checkbox"/> Patient <input type="checkbox"/> Office <input type="checkbox"/> Other: |

Important Information: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee.

Fax completed form and copy of prescription to: (833) 437-2301

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