Hematology Patient Demographics Form

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

PATIENT INFORMATION

Patient Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Alt. Phone: _____

DOB: _____ Last 4 SSN: _____

Gender: M F Height: _____ Weight: _____

Allergies:

PRESCRIBER INFORMATION

Prescriber Name: _____

State License: _____ NPI #: _____

DEA: _____

Phone: _____ Fax: _____

Address: _____

City, State, Zip: _____

Office Contact: _____

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

Primary Insurance: _____

Member ID #: _____

Plan # _____

Group #: _____

Phone: _____

Rx Card (PBM): _____

BIN: _____ PCN: _____

Group #: _____

Phone: _____

Subscriber Name/DOB: _____

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

☐ D66 Hereditary factor VIII deficiency (hemophilia A)
☐ D67 Hereditary factor IX deficiency (hemophilia B)
☐ D68.1 Hereditary factor XI deficiency (hemophilia C)
☐ D68.0 von Willebrand's disease Type:
☐ D59.5 Paroxysmal nocturnal hemoglobinuria

☐ D68.311 Acquired hemophilia
☐ D68.4 Acquired coagulation factor deficiency
☐ D68.59 Other primary thrombophilia
☐ D59.3 Hemolytic-uremic syndrome
☐ D59.5 Paroxysmal nocturnal hemoglobinuria

☐ Other Code:

Severity: ☐ MILD ☐ MODERATE ☐ SEVERE **Target Joint**: **Inhibitors**: ☐ YES ☐ 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	
☐ YES ☐ NO	☐ Peripheral ☐ Port	Patient Needs Dose by:	Ship to: ☐ Patient ☐ Office ☐ Other:

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

Thank you for choosing AvasaRX