UNIVERSAL
SPECIALTY PHARMACY

P: 855-900-8414
F: 855-710-7101
NPI: 1427588805
www.rxuniversal.com

Hemophilia & Bleeding Disorders

☐ Urgent/Stat ☐ Standard

Prescriber

Prescriber Information

Prescriber Name:		☐MD ☐PA ☐NP	
NPI:	DEA:	Office Contact:	
Address:			
City:	State:	Zip:	Phone #:	Fax #:

Patient

Patient Information - Fax A Copy Of The Front And Back Of All Insurance Cards

First Name:		MI:	Last Name:	
DOB:	Sex: ☐M ☐F	Last 4 Digits SSN :	Height:	Weight:
Address:				
City:	State:	Zip:	Primary #:	Alternate #:
Emergency Contact:	Phone #:	Contact Preference: ☐AM ☐Noon ☐PM		

Clinical

Clinical Information - Please Send Progress Notes, Lab Reports And Any Other Supporting Documents

Diagnosis – Please include diagnosis name with ICD10 code

☐ D66 Hereditary factor VIII deficiency
☐ D67 Hereditary factor IX deficiency
☐ D68.1 Hereditary factor XI deficiency
☐ Other diagnosis ICD10 code _____

☐ Severe - <1%
☐ Moderate - 1%-5%
☐ Mild - >5%

Protocol: ☐ Standard ☐ Pre-surgical ☐ Continuous Prophylaxis

Date of Diagnosis: / /
Start date / / End date / /
Next infusion date _____
Target joints ☐ No ☐ Yes _____
Infusion by ☐ Parent ☐ Patient
☐ Immune Intolerance ☐ Other _____

Prescription

Prescription Information

Dose Start Date: / / ☐New Prescription ☐Refill Prescription ☐New to Therapy ☐Restarting Therapy

Deliver to: ☐Patient's Home ☐Prescriber's Office ☐Other

Medication		Dose	Directions	Quantity	Refills
☐ Advate ☐ Alphanate ☐ Helixate ☐ Novoeight ☐ Afstyla ☐ Kogenate FS ☐ Recombinate ☐ Rixubis ☐ Xyntha	☐ Alphanine ☐ BeneFIX ☐ DDAVP ☐ Stimate ☐ Humate-P ☐ Wilate ☐ Feiba NF ☐ Novoseven	IU/KG	**Prophylaxis** Infuse _____ Units (+/-10%) slow iv-push every _____ **Breakthrough Bleed** Infuse _____ Units (+/-10%) slow iv-push every _____ hours/days (circle one) for a total of _____ doses as Needed for bleeding episodes. Minor ☐ _____ IU every _____ hour/day PRN Major ☐ _____ IU every _____ hour/day PRN ☐ **Other** _____	☐1 month ☐3 month ☐Specify	☐1 year ☐Other

Amicar Tablets Directions: _____ Qty: _____ Refill _____

Amicar Syrup Directions: _____ Qty: _____ Refill _____

☐ NaCl 0.9% Flush ☐Heparin 10 u/ml Flush ☐Heparin 100 u/ml Flush ☐ (Direction/Qty. Per flush protocol)

☐ Dispense ancillary supplies, syringes and medical equipment necessary to administer medication.

By signing this form and utilizing our services, you are authorizing Universal Specialty Pharmacy and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Sign

Prescriber Signature and Date (Required to validate prescription)

Physician Signature:	Date: / /