COTTRILL'S SP
1-844-268-8745

HEMOPHILIA PATIENT REFERRAL & Rx FORM

PLEASE INCLUDE ALL MEDICAL RECORDS AND LABS
PLEASE FAX TO 1-716-508-8482

PATIENT INFORMATION

Last Name _____ First Name _____ DOB _____

Address _____ City _____ State _____ Zip _____

Gender: ☐ Male ☐ Female Height _____ Weight _____ Social Security # _____

Home Phone _____ Cell _____ Email Address _____

Allergies _____ Emergency Contact Name _____ Phone _____

INSURANCE INFORMATION

Please provide a current copy of insurance card(s) or complete the following information

Primary Insurance _____ Policy # _____ Group # _____ Phone _____

Policy Holder's Name _____ DOB _____

Secondary Insurance _____ Policy # _____ Group # _____ Phone _____

Policy Holder's Name _____ DOB _____

CLINICAL INFORMATION AND MEDICATION

Primary Diagnosis: _____ Diagnosis Code: _____

Secondary Diagnosis: _____ Diagnosis Code: _____

Bleeding disorder type:
☐ A ☐ B ☐ vWD ☐ Other_____

Inhibitors:
☐ Yes ☐ No

Severity:
☐ Mild ☐ Moderate ☐ Severe ☐ Type vWD _____

Is patient followed at a Hemophilia Treatment Center?
☐ Yes ☐ No

If Yes, where? _____

IV Access:
☐ Peripheral ☐ Port
☐ PICC line ☐ Central line

MEDICATION

☐ Advate®	☐ Koate® DVI
☐ Adynovate®	☐ Kogenate® FS
☐ Alphanate®	☐ Mononine®
☐ AlphaNine® SD	☐ NovoSeven® RT
☐ Alprolix®	☐ Novoeight®
☐ BeneFIX®	☐ Nuwiq®
☐ Corifact®	☐ Obizur®
☐ Eloctate®	☐ Recombinate®
☐ Feiba®	☐ Rixubis®
☐ Helixate®	☐ Stimate®
☐ Hemofil®	☐ Wilate®
☐ Humate-P®	☐ Xyntha®
☐ IXINITY®	☐ Other: _____

Directions: _____

Refills: _____

PHYSICIAN INFORMATION

Physician Name _____ NPI# _____

License # _____ State _____ DEA# _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____ Office Contact _____

Product Selection Permitted **Dispense as Written** **Date**

Cottrill's will verify insurance benefits, initiate PA's and notify patient prior to admission of any out of pocket expenses or co-payments