



**PRESCRIPTION DRUG  
MEDICATION REQUEST FORM  
FAX TO 1-866-240-8123**

<b>BLOOD DISORDERS REQUEST FORM</b>			
Subscriber ID Number		Highmark Coverage <input type="checkbox"/> MA-PD <input type="checkbox"/> PDP	Group Number
Patient Name		Patient DOB	Patient Phone Number
Patient Address		City	State      Zip Code
Diagnosis Code		Dx Code Description	
Disease Severity <input type="checkbox"/> Mild (5-40%) <input type="checkbox"/> Moderate (1%-5%) <input type="checkbox"/> Severe (<1%)		Baseline Factor Level Reading (%) Baseline Level: _____ %	Patient Actual Body Weight (ABW) and Date Measured _____ kg _____ lb Date: _____
Past History of Inhibitor Development? <input type="checkbox"/> Yes <input type="checkbox"/> No		Inhibitor Currently Present? If yes—Level? <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Bethesda Units (BU)	Has patient undergone Immune Tolerance Induction? <input type="checkbox"/> Yes – inhibitor successfully tolerized <input type="checkbox"/> No <input type="checkbox"/> Yes – failed ITI
Requested Drug Name		Drug Strength or Dose	Dose calculated using Actual Body Weight (ABW) or Ideal Body Weight (IBW)? <input type="checkbox"/> ABW <input type="checkbox"/> IBW IBW: _____ kg _____ lb
Directions			Type of Therapy <input type="checkbox"/> On-Demand (PRN) <input type="checkbox"/> Prophylaxis <input type="checkbox"/> Perioperative
Requested Quantity Per Month	Refills	Ship To (please check one) <input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's Home Other _____	
Physician Signature		DEA (if applicable)	Date
<b>ALTERNATIVES TRIED BY PATIENT (IF APPLICABLE) / CLINICAL CRITERIA</b>			
Drug Name (1)		Drug Strength, Dose, and Directions	
Type of Therapy <input type="checkbox"/> On-Demand (PRN) <input type="checkbox"/> Prophylaxis <input type="checkbox"/> Perioperative		Documentation of Failure of Therapy	
Drug Name (2)		Drug Strength, Dose, and Directions	
Type of Therapy <input type="checkbox"/> On-Demand (PRN) <input type="checkbox"/> Prophylaxis <input type="checkbox"/> Perioperative		Documentation of Failure of Therapy	
Is the patient a candidate for prophylactic therapy?			Yes      No
Is there a management strategy in place?			Yes      No
If this request is for reauthorization, is there clinical documentation that the patient's condition is stable on therapy and has not progressed or worsened?			Yes      No
If any bleeding episode occurred during therapy, is there clinical documentation of the bleeding episode occurrence and type of bleeding (e.g. spontaneous bleeds, joint bleeds, etc.)?			Yes      No

**MEDICAL RATIONALE / REASON FOR DRUG THERAPY / TREATMENT PLAN****PHYSICIAN INFORMATION**

Physician Name	NPI or Tax ID #	Phone	Fax
Physician Address	City	State	Zip Code

The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.