Hemophilia Medication Request

Aetna Specialty Pharmacy®
503 Sunport Lane
Orlando, FL 32809

Customer Service: 1-866-782-ASRX (1-866-782-2779) **Fax Order Submission: 1-866-FAX-ASRX (1-866-329-2779)**

For your convenience, this medication request may be submitted via E-PRESCRIBE to Aetna Specialty Pharmacy

Aetna Specialty Pharmacy will verify benefits and contact members to confirm delivery before medication is shipped.

Today's Date: **Date Needed:**

A. PATIENT INFORMATION

First Name:	Last Name:	DOB:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
Weight:	Height:	Allergies:	

B. INSURANCE INFORMATION

Carrier Name: _____
Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, Carrier Name: _____
ID#: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, ID #: **Medicaid**: ☐ Yes ☐ No If yes, ID #:

C. PHYSICIAN INFORMATION

First Name:		Last Name:	*(Check one)*: ☐M.D. ☐D.O. ☐N.P. ☐P.A.	
Address:		City:	State:	ZIP:
Phone:	Fax:	DEA #:	NPI #:	Office Contact:

D. DIAGNOSIS

Primary ICD Code: Other ICD Code:

E. PRESCRIPTION

Please refer to the insurance carrier's participating provider precertification list to verify precertification requirements.

Medication	Directions	Quantity	Refills
☐ ADVATE ☐ ADYNOVATE ☐ AFSTYLA ☐ ALPHANATE* ☐ ALPHANINE SD ☐ ALPROLIX ☐ BEBULIN ☐ BENEFIX ☐ CORIFACT ☐ ELOCTATE ☐ FEIBA ☐ HELIXATE FS ☐ HEMOFIL M ☐ HUMATE-P ☐ IDELVION ☐ IXINITY ☐ KCENTRA ☐ KOATE-DVI ☐ KOGENATE FS ☐ KOVALTRY ☐ MONOCLATE-P ☐ MONONINE ☐ NOVOEIGHT ☐ NOVOSEVEN RT ☐ NUWIQ ☐ PROFILNINE ☐ RECOMBINATE ☐ RIASTAP ☐ RIXUBIS ☐ TRETTEN ☐ VONVENDI* ☐ WILATE* ☐ XYNTHA ☐ XYNTHA SOLOFUSE ☐ Other:	Does the patient have a current bleed? ☐Yes ☐No Assay Variation: +/- _____% ☐ Prophylaxis: _____ #_____ doses/month X _____ ☐ Immune Tolerance: _____ #_____ doses/month X _____ ☐ Breakthrough Bleeding: ☐ Minor: _____ #_____ doses/month X _____ ☐ Moderate: _____ #_____ doses/month X _____ ☐ Major: _____ #_____ doses/month X _____ ☐ Other: _____ #_____ doses/month X _____ *** Dose will be dispensed in vWF:RCo units unless otherwise specified**		

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ID#: _____
Insured:

Medicare: ☐ Yes ☐ No If yes, ID #: **Medicaid**: ☐ Yes ☐ No If yes, ID #:

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First Name:	Last Name:	*(Check one):* ☐M.D. ☐D.O. ☐N.P. ☐P.A.		
Address:	City:	State:	ZIP:	
Phone:	Fax:	DEA #:	NPI #:	Office Contact:

D. DIAGNOSIS

Primary ICD Code: Other ICD Code:

E. PRESCRIPTION

Please refer to the insurance carrier's participating provider precertification list to verify precertification requirements.

Medication	Directions	Quantity	Refills
☐ STIMATE 150mcg/actuation Nasal Spray	☐ Single spray in **one** nostril as directed (1 spray total) ☐ Single spray in **each** nostril as directed (2 sprays total) ☐ Other:		
☐ AMICAR Tablet ☐500mg ☐ 1,000mg ☐ AMICAR Oral Solution 25%			
☐ EPIPEN 0.3MG ☐ EPIPEN Jr 0.15MG	☐ Inject as needed for anaphylaxis ☐ Other:		
☐ HEPARIN **10u/mL** Flush ☐ HEPARIN **100u/mL** Flush			
☐ NORMAL SALINE Flush ☐ NORMAL SALINE **Posi**Flush			
☐ EMLA Cream			
☐ Other:			

Port Access: ☐ PIV ☐ PICC ☐ Port ☐ Other: Infused By: ☐ Patient ☐ Home Health Agency ☐ Physician

Ship to: ☐ Physician's Office ☐ Patient ☐ Other address: _____

*Interchange is mandated unless practitioner handwrites the words **"MEDICALLY NECESSARY"** for each medication.*

Prescriber's Signature **(Required by Law):**

Aetna Specialty Pharmacy refers to Aetna Specialty Pharmacy, LLC, a subsidiary of Aetna Inc., which is a licensed pharmacy that operates through specialty pharmacy prescription fulfillment. This pharmacy is a for-profit entity.