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

BLOOD DISORDERS REQUEST FORM

Subscriber ID Number	Highmark Coverage ☐ MA-PD ☐ PDP	Group Number	
Patient Name		Patient DOB	Patient Phone Number
Patient Address	City	State	Zip Code
Diagnosis Code	Dx Code Description		
Disease Severity ☐ Mild (5-40%) ☐ Moderate (1%-5%) ☐ Severe (<1%)	Baseline Factor Level Reading (%) Baseline Level: _________%	Patient Actual Body Weight (ABW) and Date Measured _________ kg _________ lb Date:______________	
Past History of Inhibitor Development? ☐ Yes ☐ No	Inhibitor Currently Present? If yes—Level? ☐ Yes ☐ No _______ Bethesda Units (BU)	Has patient undergone Immune Tolerance Induction? ☐ Yes – inhibitor successfully tolerized ☐ No ☐ Yes – failed ITI	
Requested Drug Name	Drug Strength or Dose	Dose calculated using Actual Body Weight (ABW) or Ideal Body Weight (IBW)? ☐ ABW ☐ IBW IBW: _________kg _________lb	
Directions		Type of Therapy ☐ On-Demand (PRN) ☐ Prophylaxis ☐ Perioperative	
Requested Quantity Per Month	Refills	Ship To (please check one) ☐ Physician's Office ☐ Patient's Home Other______________________	
Physician Signature	DEA (if applicable)	Date	

ALTERNATIVES TRIED BY PATIENT (IF APPLICABLE) / CLINICAL CRITERIA

Drug Name (1)	Drug Strength, Dose, and Directions
Type of Therapy ☐ On-Demand (PRN) ☐ Prophylaxis ☐ Perioperative	Documentation of Failure of Therapy
Drug Name (2)	Drug Strength, Dose, and Directions
Type of Therapy ☐ On-Demand (PRN) ☐ Prophylaxis ☐ 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.