Zarina Pharmacy
SPECIALTY & INFUSION

Skip this form & e-prescribe! Select Zarina Pharmacy from your EHR

BLEEDING DISORDER

Fax: 832-886-4298
Phone: 832-532-7239
zarinapharmacy.com

Ship To: ☐ In Office ☐ Infusion Suite ☐ At Home ☐ Other_____

PATIENT INFORMATION

Name:	SSN:		DOB:
Address:	City:	State:	ZIP:
Home Phone: / Cell:	Height:	Weight:	Gender: ○ Female ○ Male
Email:	Allergies:		

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:
Secondary Insurance:	Policy Holder:	Relationship:	Policy#:	Group#:

CLINICAL INFORMATION

Diagnosis (ICD-10): _____

☐ **D66 Hereditary Factor VIII Disorder (Hemophilia A) Severity** ☐ **mild** ☐ **moderate** ☐ **severe**
☐ **D67 Hereditary Factor IX Disorder (Hemophilia B) Severity** ☐ **mild** ☐ **moderate** ☐ **severe**
☐ **D68.0 Von Willebrand Disease Type:** ☐ **1** ☐ **2A** ☐ **2B** ☐ **2M** ☐ **2n** ☐ **3**
☐ **D68.31 1 Acquired Hemophilia**
☐ **D68.9 Coagulation defect, unspecified**
☐ **D68.2 Hereditary deficiency of other clotting factors**
☐ **D68.318 Other hemorrhagic disorder due to intrinsic circulating anticoagulants, antibodies, or inhibitors**
☐ **Other**_____

Date of Diagnosis: _____ **Comorbidities:** _____

ALLERGIES: ☐ NKDA ☐ Other _____

PRESCRIPTION INFORMATION (or attach a copy of prescription)

CLOTTING FACTOR ORDERS

☐ **Brand Name:** _____ Dose: _____ Qty: _____ Frequency: _____
☐ **Brand Name:** _____ Dose: _____ Qty: _____ Frequency: _____
Dosage: Mild units/kg _____ Severe units/kg _____
Prophylaxis: Dispense _____ dose/week for a duration of _____ months
Episodic: Dispense _____ doses for mild or _____ doses for severe

OTHER MEDICATION

☐ **Amicar®** Directions: _____ Qty: _____ Refills: _____
☐ **Lysteda®** Directions: _____ Qty: _____ Refills: _____
☐ **Stimate®** Directions: _____ Qty: _____ Refills: _____
☐ _____ Directions: _____ Qty: _____ Refills: _____

VASCULAR ACCESS DEVICE: ☐ Peripheral Catheter ☐ PICC ☐ Port

☐ Other (describe/# of lumens): _____

Flush Orders: (If IV ordered, the following flush protocols will be followed)
☐ **Sodium Chloride 0.9%**
Peripheral Line: 3 mL before each dose and 3 mL after each dose and PRN
Central Line: 5-10 mL before each dose and 5-10 mL after each dose and PRN

☐ **Other** _____

Anaphylaxis Kit Order (Infusion Reaction Management x 1/year)

☐ Epinephrine ☐ IM ☐ SUBQ Qty: _____ Refills: _____

Adult 1:1000, 0.3 mL (>30 kg/>66lbs) PRN severe allergic reaction, call 911. May repeat in 5-15 minutes as needed.

NURSING

☐ **Nursing Agency:** _____ **Phone:** _____

Skilled Nursing Visits for infliximab intravenous administration and education. To provide education related to the disease process and therapy. To provide an assessment of patient's general overall health status. To provide skilled nursing visits PRN for additional education and support.

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. ☐ Dispense as written

PHYSICIAN INFORMATION

INFUSION TYPE: ☐ **At Home** ☐ **In Office**

Prescriber Name:	Phone:	Fax:	
Office Contact:		Email:	
Address:	City:	State:	ZIP:
NPI #:		Tax ID:	
Prescriber Signature:		Date:	