MEDICA®

Hemophilia Case Review Form

Please complete this form in its entirety and provide relevant progress notes and/or bleeding diaries. All information must be faxed to 1-888-656-0841 or call 1-800-424-7892.

Patient Information		
First Name	Last Name	Patient Gender
Patient DOB	Patient Phone #	Alternative Phone #
Patient Address:		
City	State	Zip code
Prescriber Information		
Prescriber Name	Contact Name	Contact Phone #
NPI	Specialty	Fax #
Prescriber Address:		
City	State	Zip code

Pharmacy Information		
Pharmacy Name	NPI	
Contact Name	Phone #	Fax #

Primary Diagnosis

- ☐ Congenital Hemophilia A (Congenital Factor VIII Deficiency)
- ☐ Acquired Hemophilia A (Acquired Factor VIII Deficiency)
- ☐ Hemophilia B (Congenital Factor IX Deficiency)
- ☐ von Willebrand Disease
- ☐ Congenital Factor XIII Deficiency
- ☐ Congenital Factor XIII A-subunit Deficiency
- ☐ Hereditary Factor X Deficiency
- ☐ Congenital Factor VII Deficiency
- ☐ Glanzmann's Thrombasthenia

Patient Inventory (Medication on Hand)	
Total Doses on Hand	Total Units on Hand

Clinical/Prescription Information		
Name of Treating Facility		
Treatment status ☐ Treatment-naïve ☐ Treatment-experienced	Product Name	Dosing Instructions
Dose (IU) Requested by Prescriber	Number of Doses Requested	Total Dose Requested (IU)
Dates Covered (optional)	Days' Supply	Retrospective request? ☐ Yes ☐ No
Sig (if additional instructions are applicable):		

Type of Use	Place of Administration:
☐ Episodic ☐ Prophylaxis ☐ Acute Bleeding Episode ☐ Dental Procedure Date of Procedure:_____ ☐ Surgical Prophylaxis Date of Procedure:_____	☐ Home infusion ☐ Outpatient Hemophilia Treatment Center (HTC) ☐ Outpatient Hospital ☐ Provider's office ☐ Self-administration

Acute Bleeding Summary (if applicable since last request)

Bleeding 1

Date of bleed (Start)	Date of Bleed (End)
Type of Bleed: ☐Mild ☐Moderate ☐Severe	
Location of Bleed	
# of Doses Used	Total Units (IU) Used
Bleeding 2	
Date of bleed (Start)	Date of bleed (End)
Type of Bleed: ☐Mild ☐Moderate ☐Severe	
Location of Bleed	
# of Doses Used	Total Units (IU) Used

Dispensing Information (Based on Specialty Pharmacy Dispensing)					
Type of use ☐ Episodic ☐ Prophylaxis ☐ Acute Bleeding Episode ☐ Dental Procedure ☐ Surgical Prophylaxis	Unit (IU) per Dose	Vial Strength	Assay Available	# of vials Requested	Units Requested to Dispense
Type of use ☐ Episodic ☐ Prophylaxis ☐ Acute Bleeding Episode ☐ Dental Procedure ☐ Surgical Prophylaxis	Unit (IU) per Dose	Vial Strength	Assay Available	# of vials Requested	Units Requested to Dispense
Type of use ☐ Episodic ☐ Prophylaxis ☐ Acute Bleeding Episode ☐ Dental Procedure ☐ Surgical Prophylaxis	Unit (IU) per Dose	Vial Strength	Assay Available	# of vials Requested	Units Requested to Dispense
Total Days' Supply to Dispense		Total # of Doses to Dispense		Total Units Requested to Dispense	
If the Total # of Doses to Dispense differs from the Total # of Doses prescribed, please explain:					
I attest that the assay(s) requested above are the closest available to the prescribed dose (signature required):					