BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

HEMOPHILIA CASE REVIEW FORM

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.

I. Patient Information

Name	Date of Birth	Contract Number

II. Prescriber Information

Name	National Provider Identifier (NPI)

III. Patient Inventory

Total Doses on Hand	Total Units on Hand

IV. Clinical/Prescription Information

Product Name		
Dose (IU) Requested by Prescriber	Dosing Frequency	Total Dose (IU) Requested
Total Number of Doses To Dispense	Total Units Requested To Dispense	Retrospective Request ☐ Yes ☐ No
Addtional Instructions		

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

V. Acute Bleeding Summary *(if applicable since the last request)*

Bleeding

Date of Bleed (Start)	Date of Bleed (End)	Type of Bleed ☐ Mild ☐ Moderate ☐ Severe
Location of Bleed	Number 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	Number of Doses Used	Total Units (IU) Used

VI. Dispensing Information *(based on specialty pharmacy dispensing)*

Type of Use	Unit IU Per Dose	Vial Strength	Assay Available	Number of Vials Requested	Units Requested to Dispense
☐ Acute Bleeding Episode ☐ Dental Procedure ☐ Episodic ☐ Prophylaxis ☐ Surgical Prophylaxis					
Type of Use	Unit IU Per Dose	Vial Strength	Assay Available	Number of Vials Requested	Units Requested to Dispense
☐ Acute Bleeding Episode ☐ Dental Procedure ☐ Episodic ☐ Prophylaxis ☐ Surgical Prophylaxis					

I attest that the assay(s) requested above are the closest available to the prescribed dose. (Signature Required)