CareFirst Hemophilia Case Review Form

If you have questions or concerns, please call (800) 541-2934.
Fax completed form to (866) 811-7450.

CVS CAREMARK Specialty Pharmacy

Pharmacy Information

Name:	NABP:	NPI:
Contact Name:	Phone #:	Secure Fax #:

Patient Information

Last Name:	First Name:	Middle:	DOB (mm/dd/yy):
Address:	City:	State:	Zip:
Daytime Phone:	Evening Phone:	Sex:	

Insurance Information

Policy Holder's Name:	ID # on Insurance Card:
Name of Insurance Company:	Group #:

Physician Information

Name:	DEA:	NPI:
Contact Name:	Phone #:	Secure Fax #:

Primary Diagnosis

- ☐ D66 - Congenital factor VIII disorder (Hemophilia A)
- ☐ D67 - Congenital factor IX disorder (Hemophilia B)
- ☐ D68.1 - Congenital factor XI deficiency (Hemophilia C)
- ☐ D68.2 - Deficiency other clotting factors (Circle: I, II, V, VII, X, XII, XIII)
- ☐ D68.0 - von Willebrand disease (Circle type: 1, 2A, 2B, 2M, 2N, 3)
- ☐ D68.4 - Acquired coagulation factor deficiency
- ☐ D68.9 - Unspecified coagulation defects
- ☐ Other:_____ ICD-9:_____

Clinical Information

Circulating Factor Level:	Target Factor Level:	Patient Weight (kg):

Reason(s) for Use:

☐Prophylaxis Only ☐Prophylaxis and Episodic ☐Surgical Prophylaxis ☐Acute Bleeding Episode
☐ Episodic Only ☐Dental Procedure ☐ Inhibitors

Active Bleeding Summary:

Severity of Bleed: ☐ Mild ☐ Moderate ☐ Severe	Date of Bleed: From _____/_____/_____ To _____/_____/_____	Location of Bleed:
# of Doses Used:	IU/Dose Used:	

Patient Inventory (Medication on Hand)

# of Doses on Hand:	IU/Dose on Hand:

Prescription Information (Copy of Physician Rx Required)

Product Name	Directions (Dose/Frequency – Instructions per Rx)

Dispensing Information (Based on Rx)			Dispensing Information (Pharmacy Assay Availability)		
Frequency	**Dose (IU)**	**Total Doses Requested for Month**	**Assay Availability**	**Qty of Vials Dispensed**	**Total Units Dispensed**
☐Prophylaxis Use					
☐Episodic/PRN Use					

Requested Dates of Service: From _____/_____/_____ To _____/_____/_____ *Dates of service must not overlap with previous dispense without documentation of bleeding episode.

FOR INTERNAL USE ONLY DURING AFTER HOURS

Total Units Ordered Per Rx:	Total Units Approved / Provisional Approval (circle one) (add'l info requested prior to next dispense):	Pharmacist Initials: