Bright HealthCare™

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.

Patient Information		
First Name	Last Name	Prescriber Name
Patient DOB	Patient ID	Prescriber NPI

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

Clinical/Prescription Information		
Product Name		
Dose (IU) Requested by Prescriber	Dosing Frequency	Total Dose Requested (IU)
Total # of Doses to Dispense	Total Units Requested to Dispense	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	Intended Dispense Date
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	Intended Dispense Date
I attest that the assay(s) requested above are the closest available to the prescribed dose (signature required):						

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