Neighborhood Health Plan OF RHODE ISLAND™

Hemophilia Case Review Form

910 Douglas Pike, Smithfield, RI 02917 : 1-800-963-1001 : nhpri.org

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 Doses on Hand	Total 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	Unit (IU) per Dose	Vial Strength	Assay Available	# of vials Requested	Units Requested to Dispense
☐ Episodic ☐ Prophylaxis ☐ Acute Bleeding Episode ☐ Dental Procedure ☐ Surgical Prophylaxis					
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

I attest that the assay(s) requested above are the closest available to the prescribed dose (signature required):

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