



Patient Referral/Medication Request – Hemophilia

Aetna Specialty Pharmacy®
 503 Sunport Lane
 Orlando, FL 32809
Phone: 1-866-782-2779 (1-866-782-ASRX)
FAX: 1-866-329-2779 (1-866 FAX-ASRX)

Today's Date: _____

Anticipated Start Date: _____

PATIENT INFORMATION				
First Name:		Last Name:		
Address:		City:	State:	ZIP:
Home Phone:		Work Phone:		Cell Phone:
DOB:	Height:	Weight:	Email Address:	
Ship Meds to: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Doctor's Office		Allergies:		

INSURANCE INFORMATION				
Primary Insurance:			Pharmacy Benefit Manager (PBM):	
Policy #:	Group #:	Insured:	Phone:	
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, provide #:	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, provide #:	

Secondary Insurance:				
Policy #:	Group #:	Insured:	Phone:	

PHYSICIAN INFORMATION				
First Name:		Last Name:		Circle one: M.D. D.O. N.P. P.A.
Address:		City:	State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:
Office Contact Name:		Email Address:		Phone:

DIAGNOSIS	CLINICAL INFORMATION
<input type="checkbox"/> HEMOPHILIA <input type="checkbox"/> Other _____	_____

PRESCRIPTION				
MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Advate				
<input type="checkbox"/> Alphanate				
<input type="checkbox"/> AlphaNine SD				
<input type="checkbox"/> Amicar				
<input type="checkbox"/> Syrup				
<input type="checkbox"/> Tablet				
<input type="checkbox"/> Bebulin VH				
<input type="checkbox"/> BeneFIX				
<input type="checkbox"/> DDAVP				
<input type="checkbox"/> FEIBA NF				
<input type="checkbox"/> Helixate FS				
<input type="checkbox"/> Hemofil M				
<input type="checkbox"/> Humate P				
<input type="checkbox"/> Hyate C				
<input type="checkbox"/> Koate DVI				
<input type="checkbox"/> Kogenate FS				
<input type="checkbox"/> Lysteda				
<input type="checkbox"/> Monarc M				
<input type="checkbox"/> Monoclate P				
<input type="checkbox"/> Mononine				
<input type="checkbox"/> Novo Seven RT				
<input type="checkbox"/> Profilnine SD				
<input type="checkbox"/> Recombinate				
<input type="checkbox"/> Stimate				
<input type="checkbox"/> Xyntha				
OTHER:				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				

Prescriber's Signature (Required by Law): _____ **Date:** ____ / ____ / ____

Interchange is mandated unless practitioner writes the words "NO SUBSTITUTION" in this space: _____