Provider Order Form

ADYNOVATE, ANTIHEMOPHILIC FACTOR (RECOMBINANT)

Uptiv Health

PATIENT

Full Name: _____ DOB: _____

Mobile Phone: _____ Weight: _____ ☐ lbs ☐ kg

Allergies: _____ ☐ NKDA

Patient status: ☐ New to therapy ☐ Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

DIAGNOSIS ICD-10 code (must be specified)

☐ Hereditary factor VIII deficiency: hemophilia A D66 ☐ Other: _____

PROVIDER

Provider Name: _____ Provider NPI: _____

Practice Name: _____ Referral Coordinator Name: _____

Practice Address: _____

Phone: _____ Fax: _____ Email: _____

THERAPY ADMINISTRATION

Medication	Dose	Frequency
☐ ADYNOVATE, Antihemophilic Factor (Recombinant), IV	☐ Prophylaxis- 40-50 IU/kg body weight	☐ Twice weekly in adults and adolescents (12 years and older)
	☐ Prohylaxis - 55 IU/kg twice weekly	☐ Twice weekly in in children (<12 years) with a maximum of 70 IU/kg
	☐ On Demand	☐ Infuse ____ units (+/- 10%) slow IV push every ____ hours / days (circle one) for a total of ____ doses as needed for bleeding episodes. Contact your physician's office if bleeding does not resolve.

☐ Other: _____

Refills ☐ Zero ☐ 12 months ☐ _____ Order valid for 1 year unless otherwise stated.

☒ Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

LABORATORY ORDERS

☐ CBC	☐ at each dose	☐ every _____
☐ CMP	☐ at each dose	☐ every _____
☐ CRP	☐ at each dose	☐ every _____
☐ Other _____	☐ at each dose	☐ every _____

SPECIAL INSTRUCTIONS

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

☐ Patient Demographics ☐ Insurance card ☐ Progress Notes supporting DX

Provider Signature _____ Date _____