Provider Order Form

HEMLIBRA (EMICIZUMAB-KXWH)

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
☐ Hemlibra (Emicizumab-Kxwh), Subcutaneous Injection	☐ 3 mg/kg	☐ Induction Dose: 3 mg/kg Once weekly for the first 4 weeks
	☐ 1.5 mg/kg	☐ Maintenance Dose: Once a week
	☐ 3 mg/kg	☐ Maintenance Dose: Once every two weeks
	☐ 6 mg/kg	☐ Maintenance Dose: Once every 4 weeks

☐ 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 ☐ Coagulation Test Interference

Provider Signature _____ Date _____