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Michigan Department of Community Health Pharmacy Program
Hemophilia Case Review Form

☐ **URGENT REQUEST** **REQUESTED SHIP DATE:** _____ **REQUESTED SERVICE START DATE:** _____

Pharmacy Information		
NAME:		**NPI:**
CONTACT NAME:	**PHONE:**	**FAX:**

Patient Information		
LAST NAME:	**FIRST NAME:**	**DOB (MM/DD/YYYY):**
DAYTIME PHONE:	**EVENING PHONE:**	**MEDICAID ID #:**

Physician Information		
NAME:		**SPECIALTY:**
PHONE:	**FAX:**	**NPI:**

Primary Diagnosis (ICD-9 / ICD-10) ******Required: Fax will be returned if left blank******

- ☐ 286.0 / D66 – Congenital factor VIII disorder (Hemophilia A)
- ☐ 286.1 / D67 – Congenital factor IX disorder (Hemophilia B)
- ☐ 286.2 / D68.1 – Congenital factor XI deficiency (Hemophilia C)
- ☐ 286.3 / D68.2 – Deficiency of other clotting factors
- ☐ 286.4 / D68.0 – Von Willebrand disease
- ☐ 286.7 / D68.32 – Hemorrhagic dis. due to extrinsic circulating anticoagulants
- ☐ 286.7 / D68.4 – Acquired coagulation factor deficiency
- ☐ 286.9 / D68.8 – Other specified coagulation defects
- ☐ 286.9 / D68.9 – Unspecified coagulation defects

Clinical Information (Factor Levels; Weight; Reason(s) for Use)

NATIVE FACTOR LEVEL:	**TARGET FACTOR LEVEL:**	**PATIENT WEIGHT (KG):**

- ☐ Prophylaxis Only
- ☐ Episodic Only
- ☐ Inhibitors
- ☐ Prophylaxis and Episodic
- ☐ Acute Bleeding Episode
- ☐ Surgical Prophylaxis Date:_____
- ☐ Dental Procedure Date:_____

Acute Bleeding Summary

SEVERITY:	☐ Mild ☐ Moderate ☐ Severe	**DATES:** From _____ To _____	**LOCATION:**	**# OF DOSES USED:**	**TOTAL UNITS USED:**
SEVERITY:	☐ Mild ☐ Moderate ☐ Severe	**DATES:** From _____ To _____	**LOCATION:**	**# OF DOSES USED:**	**TOTAL UNITS USED:**

Patient Inventory (Medication on Hand) ******Required: Fax will be returned if left blank******

# OF DOSES ON HAND:	**TOTAL UNITS ON HAND:**

Prescription Information Per Fill (Copy of Physician Rx/Order Required)

Product Name	**Units/Dose** (IU/RCoF/MCG)	**Dates Covered:** From _____ To_____	**Total # of Doses**	**Total Units** (IU/RCoF/MCG)	**Days' Supply** (based on Rx)
		Sig/Frequency:			

Dispensing Information (Based on Rx) ***Use a separate line for each Vial Strength***				***Dispensing Information (Assay Availability)*** ***Use a separate line for each Assay Availability. Enter total at bottom.***		
Use a separate line for each Vial Strength. Rename the line as needed.	**Units/Dose** (IU/RCoF/MCG)	**Total # of Doses**	**Vial Strength** (Manufacturer's Label)	**Assay Availability**	**# of Vials Requested**	**Units** (IU/RCoF/MCG)
☐ Prophylaxis Dose						
☐ Prophylaxis Dose						
☐ Prophylaxis Dose						
☐ Prophylaxis Dose						
☐ Episodic/PRN Use						
☐ Surgery/Dental Use						
Total Days' Supply Requested to Dispense				***Total Units Requested to Dispense***		
If any of the Total Units Requested to Dispense are to replenish allowed on demand doses, please indicate units here						

Submit requests to:
Magellan Medicaid Administration
11013 W Broad Street Suite 500, Glen Allen, VA 23060
Fax: 888-603-7696 **Phone:** 877-864-9014
This form is available at https://michigan.fhsc.com → **Providers** → **Forms** → ***Hemophilia Case Review Form***

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