Clotting Disorder Individual Service Plan

Patient information

Name:	DOB:
Address:	
Phone (home):	Phone (cell):
Plan:	Member ID number:
Caregiver/responsible person: Phone (home):	Phone (cell):

Provider information

Name:	Specialty:
Office address:	
Office phone:	Office fax:
Off-hours emergency contact number:	NPI number:

Pharmacy/Clotting factor supplier information

Name:	NPI number:
Address:	
Phone:	

Clotting disorder

Diagnosis:	Severity level (Severe, Moderate, or Mild):	Presence of/history of clotting factor inhibitors:

Clotting factor replacement treatment plan

Treatment strategy: (check all that apply)	
Episodic/on-demand factor replacement	
Prophylactic replacement	
Immune Tolerance Therapy	

Treatment goals:

Clotting factor product(s) prescribed:	Dose:	Frequency:	Indication:

Adjunctive therapies (if any):

Emergency care plan (what should the enrollee do in case of trauma or bleeding emergencies):

Clotting factor product administration

Please indicate the ancillary supplies (needles, syringes, sterile wipes, Tegaderm patches, etc.) needed to administer the clotting factor product(s).

Please indicate if any equipment, vascular access devices, and assistive technology are needed to facilitate the administration of the clotting factor product(s).

Please indicate if any home health or other out-patient assistive services are needed to facilitate the administration of the clotting factor product(s).
Out-patient assistive service provider name: Address: Phone: Fax: Service frequency:

Provider name:

Provider signature:

Date: