State of Oklahoma
Oklahoma Health Care Authority

Hemophilia and Other Rare Bleeding Disorders
Patient Consent to Treat

Member Name: _____ ***Date of Birth:***_____ ***Member ID#:***_____

Pharmacy NPI: _____ ***Pharmacy Name:*** _____ ***PIC:***_____

Pharmacy Phone:_____ ***Pharmacy Fax:*** _____

To be completed by member during yearly in-home assessment.
Please Initial after each line and sign at the bottom. Please complete all applicable blanks.

1. I agree to allow an in-home assessment on a yearly basis to verify the below items. **Initials_____**
2. I have been counseled and understand how to properly store my factor replacement product(s). **Initials_____**
3. I have been counseled and understand how to properly store the supplies that go with my factor replacement product(s). **Initials _____**
4. I have been counseled and understand how to rotate my factor stock so factor does not expire before using it. (In some patients with mild hemophilia, it may not be possible to avoid factor expiring.) **Initials _____**
5. I have been taught and understand how to properly dispose of sharps and biohazardous materials. **Initials _____**
6. I have been instructed on how to properly dispose of a full sharps/biohazardous container and obtain a new one. **Initials _____**
7. I will use the factor exactly how my doctor instructed. **Initials_____**
8. I agree to keep a record/log of my factor infusions and send the infusion log to my doctor on a regular basis. **Initials _____**
9. I understand the benefits of being seen at a comprehensive hemophilia treatment center such as the Oklahoma Center for Bleeding and Clotting Disorders. **Initials_____**
10. I understand I may be contacted by an OHCA care management nurse to discuss my treatment. **Initials_____**
11. I understand the information given to me on the following additional topics:

_____ **Initials _____**
_____ **Initials _____**
_____ **Initials _____**
_____ **Initials _____**

I have read, understand, and agree to the above statements.
Member Signature: _____ Date: _____
Pharmacy Staff Signature: _____ Date: _____

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit

Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

SoonerCare
Oklahoma Health Care Authority