Coagadex®
Coagulation Factor X (Human)

NEW PATIENT START FORM

COAGADEX® Support Services – Provided Through Medmonk

Medmonk
Phone: 888-262-8040
Fax: 408-419-1768

Please complete all pages and fax to Medmonk for benefit verification.
- **Medmonk review may help to prevent delays and facilitate access to COAGADEX.**
- **Questions? Please call Medmonk directly.**

SPECIALTY PHARMACY

Preferred pharmacy (please select one):

Accredo	CVS	Option Care	Optum	Paragon	PromptCare	Soleo
P: 866-712-5200	P: 866-792-2731	P: 866-436-4376	P: 866-442-4679	P: 888-588-1027	P: 877-776-6782	P: 844-547-8600
F: 877-329-4605	F: 800-323-2445	F: 888-688-3593	F: 800-311-0185	F: 866-388-1488	F: 800-889-0862	F: 380-257-2419

How Medmonk assists you:
- Medmonk confirms that your selected pharmacy is a preferred partner under your patient's health insurance coverage. If your choice is not a preferred partner, Medmonk will select one that is.
- Medmonk will send prescription to selected Specialty Pharmacy.

PATIENT INFORMATION

Patient name:

Date of birth: / / Sex: M F

Address:

City: State: Zip code:

Phone: Email:

Preferred method of contact: Phone Text Email

Best time to contact: Morning (8 AM–10 AM ET) Day (10 AM–5 PM ET) Evening (5 PM–8 PM ET)

If the patient is under 18 years of age:

Primary contact/caregiver name:

Relationship to patient:

Phone: Text: Email:

INSURANCE INFORMATION
Attach a copy of the front and back of all applicable insurance cards, if available.

Patient currently does not have insurance.

Patient currently has insurance. Copy of patient's insurance card(s) attached.

If a copy of the insurance card(s) is not attached, please complete the required information below:

Primary insurance type: Private/commercial Medicaid – State Other

Primary insurance name: Email:

Beneficiary/cardholder name:

Cardholder relationship to patient:

Policy ID #: Group ID #:

Prior authorization required? Yes No

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KEDRION BIOPHARMA

NEW PATIENT START FORM
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Patient Name: ______________________

ICD-10-CM DIAGNOSIS CODE / DESCRIPTION

D68.2 Hereditary deficiency of other clotting factors (Deficiency of factor X [Stuart-Prower])

____

FACTOR X LEVEL

Baseline plasma factor X activity level (without treatment)

__________ %

Test date: _____/_____/_____

COAGADEX PRESCRIBED DOSING

Refer to COAGADEX Prescribing Information for details on recommended adult and child dosing.
For convenience, access the **COAGADEX Dosing App** at www.Coagadex.com/hcp/dosing-app

ADULT / ADOLESCENT (≥12 YEARS)

Fill in and check boxes below for desired dosing:

Weight: _______ kg Anticipated start date: _______/_______ /_______

For routine prophylaxis:

Recommended dose: 25 IU/kg IV 2 times weekly

Dose: _______ IU/kg IV _______ times weekly

For on-demand treatment of bleeding episodes:

Recommended initial dose: 25 IU/kg IV
Infuse at first sign of bleeding. Repeat at 24-hour intervals until the bleed stops.

Initial dose: _______ IU/kg IV

For perioperative management:

Pre-surgery recommended dose: ______ IU (total) IV
Calculate the dose to raise plasma factor X levels to 70–90 IU/dL, using one of these equations:

______ IU (total) = ______ kg x ______ IU/dL x 0.5
*Body weight | Desired factor X rise**

______ IU (total) = ______ kg x ______ % of normal x 0.5
*Body weight | Desired factor X rise**

Pre-surgery dose: ______ IU (total) IV

Post-surgery recommended dose: ______ IU (total) IV
Repeat dose as necessary to maintain plasma factor X levels at ≥50 IU/dL until the patient is no longer at risk of bleeding due to surgery. Calculate using above equations.

Post-surgery dose: ______ IU (total) IV

Notes:

CHILD (<12 YEARS)

Fill in and check boxes below for desired dosing:

Weight: _______ kg Anticipated start date: _______/_______ /_______

For routine prophylaxis:

Recommended dose: 40 IU/kg IV 2 times weekly

Dose: _______ IU/kg IV _______ times weekly

For on-demand treatment of bleeding episodes:

Recommended initial dose: 30 IU/kg IV
Infuse at first sign of bleeding. Repeat at 24-hour intervals until the bleed stops.

Initial dose: _______ IU/kg IV

For perioperative management:

Pre-surgery recommended dose: ______ IU (total) IV
Calculate the dose to raise plasma factor X levels to 70–90 IU/dL, using one of these equations:

______ IU (total) = ______ kg x ______ IU/dL x 0.6
*Body weight | Desired factor X rise**

______ IU (total) = ______ kg x ______ % of normal x 0.6
*Body weight | Desired factor X rise**

Pre-surgery dose: ______ IU (total) IV

Post-surgery recommended dose: ______ IU (total) IV
Repeat dose as necessary to maintain plasma factor X levels at ≥50 IU/dL until the patient is no longer at risk of bleeding due to surgery. Calculate dose using above equations.

Post-surgery dose: ______ IU (total) IV

Notes:

COAGADEX ADMINISTRATION

Infusion rate

Recommended IV infusion rate: 10 mL/min, not to exceed 20 mL/min

Other IV infusion rate: _______ mL/min, not to exceed _______ mL/min

IV access

Peripheral

Other (describe): ______________________________

COAGADEX DISPENSING

Dispense _______ month supply with _______ refills.

Dispense _______ IUs _______ 250 IU vials _______ 500 IU vials

Number of refills: ________

*The desired factor X rise is the difference between the patient's plasma factor X level and the maximum desired level, expressed as IU/dL or % of normal.

Patient Name:

ADDITIONAL DRUG ORDERS (dispense quantity sufficient for month supply unless otherwise noted)

Decline

Other, please describe:

ANCILLARY SUPPLIES (dispense sufficient quantity)

Ancillary supplies as necessary to administer COAGADEX® including equipment (eg, needles, syringes), devices and disposables.

SITE OF CARE AND NURSING REQUIREMENTS

Site of care:

Home infusion

Physician office

Infusion clinic

Outpatient hospital

Inpatient hospital

Other:

Who will administer COAGADEX?

Patient

Caregiver

Nurse

Nurse initially, then patient/caregiver later

For home infusion only: Nursing and training requirements (check all that apply):

Nurse needed to administer therapy at home per physician orders.

Nurse to obtain IV access via placement of peripheral IV catheter or butterfly needle. If peripheral IV, may leave in place up to 5 days as long as no erythema or edema.

Nurse needed to instruct patient in self-infusion.

Nurse needed to instruct caregiver in administering patient's infusion.

Number of skilled nursing visits needed to support at-home COAGADEX infusion:

1 2 3 4 5 6 PRN/as needed

Do you want specialty pharmacy to coordinate nursing and training for this patient's COAGADEX infusions? Yes No

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Patient Name: ______________________

AUTHORIZING HEALTHCARE PROVIDER INFORMATION

First name: | Last name:

Address:

City: | State: | Zip code:

Phone (cell/work): | Text: | Email:

Practice phone: | Practice fax:

Practice contact first and last name:

Practice contact phone: | Practice contact email:

INFUSION SITE OFFICE INFORMATION

No infusion site office is needed.

Infusion site office is the same as the provider's office (information listed above).

Infusion site office is different from the provider's office. Please complete section below.

Practice or facility name:

Contact first and last name:

Phone: | Fax: | Email:

PRESCRIBER AUTHORIZATION

I certify that COAGADEX® is medically necessary for this patient. I will be supervising the patient's treatment accordingly. Non-approval of COAGADEX® may result in further deterioration of the patient's health and/or hospitalization. By signing below, I certify that I have received the necessary authorization from the patient to release the medical and/or patient information referenced on this form relating to the above-referenced patient to the contracted agent or contractors working for Kedrion Biopharma solely on behalf of the patient for the purpose of seeking reimbursement, verifying insurance coverage and/or the evaluation of the patient's eligibility for alternate sources of funding, patient support services, including materials fulfillment, and product fulfillment via specialty pharmacies.

Dispense COAGADEX® As Written / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute

Prescriber's Signature: ______________________

Date: _______/_______ /_____________

May Substitute / Product Selection Permitted / Substitution Permissible

Prescriber's Signature: ______________________

Date: _______/_______ /_____________

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words **"No Substitution":** ______________________

ATTN: New York and Iowa providers, please also submit electronic prescription.

PLEASE FAX COMPLETED FORM WITH SIGNATURE TO MEDMONK AT 408-419-1768.

This form serves as your signed prescription—do not fax a separate prescription.

Protected Health Information (PHI) will not be shared with any employee of Kedrion Biopharma.

Please see accompanying Full Prescribing Information for complete prescribing details.

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