

**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:** _____

<p><u>PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:</u></p> <p style="text-align: center;">University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit</p> <p style="text-align: center;">Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4</p>	<p style="text-align: center;"><u>CONFIDENTIALITY NOTICE</u></p> <p style="text-align: center;"><i>This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.</i></p>
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