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Maryland Medicaid Pharmacy Programs RECIPIENT-KEPT CLOTTING FACTORS ADMINISTRATION RECORD

Phone: 800-492-5231 or 410-767-5701 • Fax: 410-333-5398 • PO Box 2158, Baltimore, MD 21201

Recipient: _____ MA#: _____ Phone# (____)____ - _____
 Current Address: _____
 Physician: _____ Phone# (____)____ - _____ Fax# (____)____ - _____
 Patient's Case Manager: _____ Phone# (____)____ - _____ Fax# (____)____ - _____

Date/Time Check (I) for Infusion or (D) Delivery	Units Received (to be added) or Units Infused (to be subtracted) — Specify units per vial and number of vials	Units On-hand after last dose-Specify units per vial and number of vials remaining in the refrigerator	Explain any unusual bleed(s) requiring additional doses- Notify Doctor of such bleed. Specify location where drug is infused if other than home.
I D	U/vial _____ x # vials _____ U/vial _____ x # vials _____ U/vial _____ x # vials _____	U/vial _____ x # vials _____ U/vial _____ x # vials _____ U/vial _____ x # vials _____	
I D	U/vial _____ x # vials _____ U/vial _____ x # vials _____ U/vial _____ x # vials _____	U/vial _____ x # vials _____ U/vial _____ x # vials _____ U/vial _____ x # vials _____	
I D	U/vial _____ x # vials _____ U/vial _____ x # vials _____ U/vial _____ x # vials _____	U/vial _____ x # vials _____ U/vial _____ x # vials _____ U/vial _____ x # vials _____	
I D	U/vial _____ x # vials _____ U/vial _____ x # vials _____ U/vial _____ x # vials _____	U/vial _____ x # vials _____ U/vial _____ x # vials _____ U/vial _____ x # vials _____	
I D	U/vial _____ x # vials _____ U/vial _____ x # vials _____ U/vial _____ x # vials _____	U/vial _____ x # vials _____ U/vial _____ x # vials _____ U/vial _____ x # vials _____	
I D	U/vial _____ x # vials _____ U/vial _____ x # vials _____ U/vial _____ x # vials _____	U/vial _____ x # vials _____ U/vial _____ x # vials _____ U/vial _____ x # vials _____	
I D	U/vial _____ x # vials _____ U/vial _____ x # vials _____ U/vial _____ x # vials _____	U/vial _____ x # vials _____ U/vial _____ x # vials _____ U/vial _____ x # vials _____	
I D	U/vial _____ x # vials _____ U/vial _____ x # vials _____ U/vial _____ x # vials _____	U/vial _____ x # vials _____ U/vial _____ x # vials _____ U/vial _____ x # vials _____	

The balance on-hand given to the pharmacist at the time of the call on ____/____/____ is: _____ U
mo day year

Original Signature of Recipient or Caregiver's: _____ **Date:** ____/____/____
mo day year

Name: _____ Relationship to the Patient: _____

NOTE: This form is mandatory and may be duplicated. Recipient or Caregiver must keep a record of Recipient's clotting factor infusions and bleeds for the purpose of monitoring compliance and bleeding patterns. The form should be sent to the specialty pharmacy when an order is placed. The pharmacist should ask for the balance of units on-hand at the time of the order and submit this form to the State along with the required paperwork.