

**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 Circle (I) for Infusion or (D) for 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

Original Signature of Recipient or Caregiver's: _____ Date: ____/____/____

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