Maryland Medicaid Pharmacy Programs
PHARMACIST CLOTTING FACTOR DISPENSING RECORD

A six-month clotting factor dispensing record and a copy of the previous month's Recipient-Kept Clotting Factors Administration Record must accompany each factor invoice that is submitted to the Program. Vial potencies and lot numbers must be documented on this sheet. The balance of units on hand must be given by the Recipient or Caregiver to the pharmacist when placing a new order.

Recipient:_____MA#:_____Phone# (____)_____-_____
Address: _____
Physician:_____Phone# (____)_____-_____Fax#(_____)_____-_____
Address:_____
Case Manager:_____Phone# (_____)_____-_____Fax# (____)_____-____
Clotting Factor: _____

Date of Service, starting with most recent	Total Units Dispensed by Pharmacy*	# of Vials/ Assay Potencies/ Lot numbers	Total Units Infused Prior to New Shipment	Actual Units On Hand as Reported by Recipient	Order Changes/Unusual Bleeds- Specify location where drug is infused if other than home.

* No more than 6 doses of drug should be kept on-hand at any time for recipient's on-demand use . Emergency supplies are automatically authorized for active bleeds.

I certify that all data submitted are accurate and that I will be monitoring the recipient's proper utilization of the clotting factors. Supporting documentation available for State audits.

Pharmacist's Original Signature: _____Date:_____
Pharmacist Name:_____
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