PYRAMIDS
SPECIALTY PHARMACY

Hematopoietic Enrollment Form (A-M)

www.pyramidspharmacy.com

All our referral forms are available on our website.

10970 Shadow Creek Pkwy, Suite 110.1 I Pearland, TX 77584 I Phone: 1.888.375.1920 I Fax: 1.888.383.2140

1: Patient Information

Patient Name: ______ Birthdate: ______ Sex: Male Female Height: ______ Weight: ______ ❑lbs. ❑kg.

Soc. Sec. #: ______ Preferred Phone: ______ Known Allergies: ______

Address: ______ City: ______ State: ______ Zip: ______

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

Plan Name: ______ Plan Phone: ______

ID #: ______ Group #: ______ RxBIN: ______ RxPCN: ______

2: Prescriber Information

Prescriber Name: ______ DEA#: ______ NPI#: ______ Tax ID#: ______

Address: ______ Phone: (____) ______ - ______ Fax: (____) ______ - ______

City: ______ State: ______ Zip: ______ Key Contact: ______ Phone: (____) ______ - ______

3: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

Diagnosis (ICD-10):

❑ D61.9 Aplastic Anemia
❑ D63.1 Anemia in Chronic Kidney Disease
❑ D64.81 Anemia due to Antineoplastic Chemotherapy
❑ D69.3 Immune Thrombocytopenic Purpura
❑ Other: ______

Patient Dosing Weight:

______ kg/lbs

Please attach all relevant labs, tests, and clinicals.

Previously tried and failed therapies and reason for discontinuation:

______
______
______
______
______

4: Prescription Information

Medication	Strength	Directions	Quantity	Refills
❑ Aranesp®	❑ 10 mcg ❑ 150 mcg ❑ 25 mcg ❑ 200 mcg ❑ 40 mcg ❑ 300 mcg ❑ 60 mcg ❑ 500 mcg ❑ 100 mcg ❑ Prefilled Syringe ❑ Vial	❑ Inject entire contents of one PFS/Vial subQ once a week. ❑ Inject entire contents of one PFS/Vial subQ every 2 weeks. ❑ Inject entire contents of one PFS/Vial subQ every 4 weeks. ❑ Other: ______		
❑ Epogen®	❑ 2,000 Units/mL Vial (SDV) ❑ 3,000 Units/mL Vial (SDV) ❑ 4,000 Units/mL Vial (SDV) ❑ 10,000 Units/mL Vial (SDV) ❑ 20,000 Units/mL Vial (MDV) ❑ 20,000 Units/2 mL Vial (MDV)	❑ **SDV**: Inject entire contents of one vial subQ ❑ once weekly. ❑ three times a week. ❑ Other: ______ ❑ **MDV**: Inject ______ Units (______ mL) subQ ❑ once weekly. ❑ three times a week. ❑ Other: ______		
❑ Fulphila™	❑ 6 mg/0.6 mL Prefilled Syringe	❑ Inject 6 mg subQ once per chemotherapy cycle. (Not to be administered in the period 14 days before and 24 hours after administration of cytotoxic chemotherapy.)		
❑ Granix®	❑ 300 mcg PFS ❑ 300 mcg/mL Vial (SDV) ❑ 480 mcg PFS ❑ 480 mcg/1.6 mL Vial (SDV)	❑ Inject ______ mcg (5 mcg/kg) subQ once daily for ______ days.		
❑ Leukine®	❑ 250 mcg Single-Dose Vial (lyophilized powder)	❑ Administer ______ mcg once daily for ______ days. ❑ IV ❑ subQ ❑ Other: ______		
❑ Mozobil®	❑ 24 mg/1.2 mL Vial	❑ Inject ______ mg subQ once daily for ____ days. (Up to 4 days, not to exceed 40 mg/day)		
❑ Mulpleta®	❑ 3 mg Tablet	❑ Take one tablet by mouth once daily with or without food for 7 days, starting 8 to 14 days prior to scheduled procedure. Do not begin dosing until the date instructed by your physician or pharmacy.		

Deliver to: ❑Patient ❑Office ❑Other: ______ Date: ______ Needs by Date: ______

*Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

❑Product Substitution Permitted ❑Dispense as Written

STAMP SIGNATURE NOT ALLOWED Prescriber's Signature: ______ Date: ______

CONFIDENTIALITY STATEMENT: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone.