

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): <input type="checkbox"/> D61.9 Aplastic Anemia <input type="checkbox"/> D63.1 Anemia in Chronic Kidney Disease <input type="checkbox"/> D64.81 Anemia due to Antineoplastic Chemotherapy <input type="checkbox"/> D69.3 Immune Thrombocytopenic Purpura <input type="checkbox"/> Other: _____	Patient Dosing Weight: _____ kg/lbs Please attach all relevant labs, tests, and clinicals.	Previously tried and failed therapies and reason for discontinuation: _____ _____ _____ _____
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4: Prescription Information

Medication	Strength	Directions	Quantity	Refills
<input type="checkbox"/> Neulasta®	<input type="checkbox"/> 6 mg Prefilled Syringe <input type="checkbox"/> 6 mg/0.6 mL ONPRO KIT	<input type="checkbox"/> 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.) <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Neupogen®	<input type="checkbox"/> 300 mcg Vial <input type="checkbox"/> 300 mcg Prefilled Syringe <input type="checkbox"/> 480 mcg Vial <input type="checkbox"/> 480 mcg Prefilled Syringe	<input type="checkbox"/> Administer _____ mcg once daily for _____ days. <input type="checkbox"/> IV <input type="checkbox"/> subQ <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Nplate®	<input type="checkbox"/> 250 mcg Vial <input type="checkbox"/> 500 mcg Vial	<input type="checkbox"/> Inject _____ mcg subQ once weekly.		
<input type="checkbox"/> Procrit®	<input type="checkbox"/> 2,000 Units/mL Vial (SDV) <input type="checkbox"/> 3,000 Units/mL Vial (SDV) <input type="checkbox"/> 4,000 Units/mL Vial (SDV) <input type="checkbox"/> 10,000 Units/mL Vial (SDV) <input type="checkbox"/> 40,000 Units/mL Vial (SDV) <input type="checkbox"/> 20,000 Units/mL Vial (MDV) <input type="checkbox"/> 20,000 Units/2 mL Vial (MDV)	<input type="checkbox"/> SDV: Inject entire contents of <u>one</u> vial subQ <input type="checkbox"/> once weekly. <input type="checkbox"/> three times a week. <input type="checkbox"/> Other: _____ <input type="checkbox"/> MDV: Inject _____ Units (_____ mL) subQ <input type="checkbox"/> once weekly. <input type="checkbox"/> three times a week. <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Promacta®	<input type="checkbox"/> 12.5 mg Tablet <input type="checkbox"/> 25 mg Tablet <input type="checkbox"/> 50 mg Tablet <input type="checkbox"/> 75 mg Tablet	<input type="checkbox"/> Take one tablet by mouth once daily on an empty stomach, 1 hour before or 2 hours after a meal.		
<input type="checkbox"/> Retacrit®	<input type="checkbox"/> 2,000 Units/mL Vial (SDV) <input type="checkbox"/> 3,000 Units/mL Vial (SDV) <input type="checkbox"/> 4,000 Units/mL Vial (SDV) <input type="checkbox"/> 10,000 Units/mL Vial (SDV) <input type="checkbox"/> 40,000 Units/mL Vial (SDV)	<input type="checkbox"/> Inject entire contents of <u>one</u> vial subQ <input type="checkbox"/> once weekly. <input type="checkbox"/> three times a week. <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Zarxio®	<input type="checkbox"/> 300 mcg Prefilled Syringe <input type="checkbox"/> 480 mcg Prefilled Syringe	<input type="checkbox"/> Administer _____ mcg once daily for _____ days. <input type="checkbox"/> IV <input type="checkbox"/> subQ <input type="checkbox"/> Other: _____		

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: _____