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| <input type="checkbox"/> New to Therapy |
| <input type="checkbox"/> Current Therapy |

Patient Information

Patient Name: _____
 Date of Birth: _____ Sex: M or F Caregiver: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Home Phone: _____ Work Phone: _____
 Cell Phone: _____ E-mail: _____
 Please attach copy of front and back of patient's prescription ins. card(s) if applicable
 Insurance Company Name: _____
 Insurance Company Phone: _____
 Policy holder: _____
 Policy holder Employer: _____
 Relationship to Patient: _____
 ID# _____ Group# _____
 RxBIN: _____ RxPCN: _____

Prescriber Information

Practice/ Organization Name: _____
 Prescriber Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone#: _____ Fax#: _____
 DEA# _____ NPI# _____
 License#: _____ Medicaid UPIN#: _____
 Physician Specialty: _____

Date Shipment Needed: _____
Ship to: Patient Prescriber Other: _____
 Shipment Address: _____ Attn: _____
 City: _____ State: _____ Zip: _____
If shipped to the prescriber's office, Prescriber accepts on behalf of patient for administration in office.

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Clinical Information and Prescription

Primary Diagnosis (ICD10): ____ . ____ Description: _____
 Secondary Diagnosis (ICD10): ____ . ____ Description: _____
 Date of Diagnosis or Years with Disease: _____
 Patients Allergies: _____
 Latex allergy: Yes No Patient Weight: _____ Patient Height: _____

Medical History -Please attach all lab/test results/treatment plans

| | | | | | |
|-----------------------|----------|-----------------------|----------|-----------|----------|
| Hemoglobin | Lab Date | Hematocrit | Lab Date | Platelets | Lab Date |
| % | / / | g/dl | / / | | / / |
| WBC | Lab Date | ANC | Lab Date | Ferritin | Lab Date |
| cells/mm ³ | / / | cells/mm ³ | / / | | / / |

Comorbidities: _____
 Expected First Dose Date: _____ Injection Instruction needed: Yes No

- Aranesp® (darbepoetin alfa)**
 Single Dose Vial: 25mcg/ml 40mcg/ml 60mcg/ml 100mcg/ml
 150mcg/0.75ml 200mcg/ml 300mcg/ml
 SingleJect® PFS: 10mcg/0.4ml 25mcg/0.42ml 40mcg/0.4ml 60mcg/0.3ml 100mcg/0.5ml
 150mcg/0.3ml 200mcg/0.4ml 300mcg/0.6ml 500mcg/ml
- Epogen® (epoetin alfa)** 2,000 units 3,000 units 4,000 units 10,000 units
 20,000 units (multidose vial)
- Leukine® (sargramostin)** 250mcg lyophilized powder for inj 500mcg soln for inj
- Neulasta® (pegfilgrastim) OR Fulphila (pegfilgrastim-jmdb)**
 0.6mg/0.6ml Prefilled Syringe 0.6mg/0.6ml Onpro Injection Kit (Neulasta only)
- Neupogen® (filgrastim) OR Zarxio® (filgrastim-sndz) OR Granix® (Tbo-filgrastim)**
 300mcg/0.5ml Prefilled Syringe 300mcg/ml vial (Neupogen only)
 480mcg/0.8ml Prefilled Syringe 480mcg/1.6ml vial (Neupogen only)
- Procrit® (epoetin alfa)** 2,000 units 3,000 units 4,000 units 10,000 units
 40,000 units 20,000 units (multidose vial)
- Promacta® (eltrombopag)** 12.5 mg tablets 25 mg tablets 50 mg tablets 75 mg tablets

Dose: Inject _____ mcg/kg or _____ mcg/m² via IV Subcutaneously Continuous SC

Directions: _____

Quantity: QS 30 days Other: ____ Refills Authorized: 0 1 3 6 11 Other: ____

Prescriber Signature: X _____ Date: ____/____/____