ANEMIA REFERRAL FORM

Updated July 2019

Patient Name _____ Today's Date_____ ☐ *NEW* Patient ☐ *CURRENT Patient*
DOB _____ Height _____ Weight _____ ☐ Male ☐ Female Preferred Language _____
Best Phone _____ Email _____
Street Address _____ Apt#_____ City _____ State _____ Zip _____
Ship to Patient at: ☐ Home ☐ Physician Office ☐ Work Address _____
Allergies _____
Current Medications including OTC's (*please fax a complete list*) _____

Please Fax Insurance Card(s) both sides
Insured's Name _____
Relation to Patient _____
Primary Insurance _____
ID# _____ Group # _____
Secondary Insurance _____
ID# _____ Group # _____

Ordering Prescriber _____
Office Contact _____
Street Address _____ Suite #_____
City _____ State _____ Zip _____
Tel _____ Fax _____
Email _____
License# _____
NPI# _____

ICD-10 Code ☐ _____ **Secondary ICD-10 Code** ☐ _____ Diagnosis _____
Date of diagnosis _____
☐ **Yes** ☐ **No** Is Patient new to therapy?
☐ **Yes** ☐ **No** Is Anemia due to chemotherapy?
☐ **Yes** ☐ **No** Previously treated for this condition? Medications Failed _____

All lab reports must be from within the last 30 days

PRESCRIPTION

☐ **NEUPOGEN** ☐ 300 mcg SQ ☐ 480 mcg SQ ☐ Other_____
SIG: ☐ Daily x_____days ☐ Every week ☐ BIW ☐ TIW
QTY: _____ Refill: _____

☐ **PROCRIT** ☐ 10,000 units SQ ☐ 20,000 units SQ ☐ 40,000 units SQ ☐ Other_____
SIG: ☐ Every week
☐ Other_____
QTY: _____ Refill: _____

☐ **NEULASTA 6 mg/0.6 mL solution in a single-dose prefilled syringe** ☐ Other_____
SIG: ☐ 6 mg administered subcutaneously
☐ Other_____
QTY: _____ Refill: _____

☐ **NEULASTA 6 mg/0.6 mL ONPRO Kit** ☐ Other_____
SIG: ☐ 6 mg administered subcutaneously
☐ Other_____
QTY: _____ Refill: _____

☐ **OTHER** _____ SIG: _____ QTY: _____ Refill: _____

LIST ANCILLARY SUPPLIES IF NEEDED _____

☐ **ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM**

Prescriber's Signature (signature required. NO STAMPS)_____ **Date** _____

My signature certifies that the person named on this form is my patient and that the information provided on this enrollment form is complete and accurate to the best of my knowledge. I certify this therapy to be medically necessary.

My signature authorizes The Pharmacy and its representatives to act as the agent to execute the insurance prior authorization process, assist the above named patient enroll into patient support programs, and appeal on behalf of prescriber and patient in the event of a prior authorization denial.

PLEASE NOTE: The Pharmacy can only accept original prescription drug orders from patients, faxed prescriptions can be accepted only from the prescribing practitioners.