

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.

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