Hematopoietic Enrollment Form (A-M)

PATIENT INFORMATION

Patient Name: ____
Date of Birth: _____ / _____ / _____ ☐ Male ☐ Female
SSN: _____ - _____ - _____
Address: ____
City: ___________________ State: ________ Zip: _____________

Phone: (_____) - _____ - ________
Email: ____
Preferred method of contact: ☐ Phone ☐ Email
Height: ________ in Weight: ________ lb Date: _____ / _____ / _____
Allergies: Medications: (Please attach additional pages if necessary)

PRESCRIPTION BENEFITS INFORMATION (Please attach front and back of insurance card)

Plan name: ____________________________ ID#: ________________________ Group #: _______________ RxBIN: ___________ RxPCN: ___________

PRESCRIBER INFORMATION

Prescriber Name: ____
Address: ____
City: ___________________ State: ________ Zip: _____________
Contact: _______________ Clinic/Hospital Affiliation: _____________

Phone: (_____) - _____ - ________ Fax: (_____) - _____ - ________
License #: ____
NPI #: ____
Medicaid Provider #: ____

HEMAMRX-20-01

CLINICAL CONSIDERATIONS

Diagnosis:
☐ D63.1 Anemia in chronic kidney disease
☐ D64.81 Anemia due to antineoplastic chemotherapy
☐ Other: ________________________________

History of therapies tried/failed (please include dates):

Immunization History
☐ Influenza: ____ /____ / ____

℞

Medication	Dose/Strength	Directions	Quantity	Refills
☐**Aranesp®** (darbepoetin alfa)	☐ 10 mcg ☐ 150 mcg ☐ 25 mcg ☐ 200 mcg ☐ 40 mcg ☐ 300 mcg ☐ 60 mcg ☐ 500 mcg ☐ 100 mcg ☐ Prefilled syringe ☐ Vial	☐ Inject ___ mcg subcutaneously once every 2 weeks ☐ Inject ___ mcg subcutaneously once a week ☐ Other: ________________________________		
☐**Epogen®** (epoetin alfa)	☐ 2,000 units/mL (SDV) ☐ 3,000 units/mL (SDV) ☐ 4,000 units/mL (SDV) ☐ 10,000 units/mL (SDV) ☐ 10,000 units/mL 2mL vial (MDV) ☐ 20,000 units/mL 1mL vial (MDV)	☐ Single-dose Vial (SDV): Inject the entire contents of 1 vial subcutaneously ☐ Once a Week ☐ 3 Times a Week ☐ Other:______________________________ ☐ Multi-dose Vial (MDV): Inject _____mL (_____ units) subcutaneously ☐ Once a Week ☐ 3 Times a Week ☐ Other:______________________________ ☐ Other:________________________________		
☐**Fulphila™** (pegfilgrastim-jmdb)	☐ 6 mg prefilled syringe	☐ Inject 6 mg (1 syringe) subcutaneously once per chemotherapy cycle (at least 24 hours after chemotherapy)		
☐**Granix®** (tbo-filgrastim)	☐ 300 mcg ☐ 480 mcg ☐ Prefilled syringe ☐ Vial	☐ Administer _____ mcg (____ mcg/kg/day x ____ kg) subcutaneously once a day for ____ days (at least 24 hours after chemotherapy)		
☐**Leukine®** (sargramostim)	☐ 250 mcg vial (lyophilized, SDV)	☐ Administer _____ mcg (____ mcg/m^2/day x ____ m^2) once a day for ____ days (Circle IV or SC) ☐ Other:________________________________		

Injection Training
Injection training provided by ☐ Prescriber's Office ☐ Specialty Pharmacy ☐ Other: ______________________________

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's Signature: ______________________________ ☐ MD ☐ DO ☐ PA ☐ CRNP **Date:** ____ /____ / ____

NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

SHIPPING INFORMATION

Ship to: ☐ Patient ☐ Physician/Clinic Date Shipment Needed By: ____ / _____ / _____

PHONE: 855-726-8479 (412-246-9858) **FAX**: 855-246-3986 (412-787-9400) **www.pantherxrare.com**

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