Hematopoietic Enrollment Form (N-Z)

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 #: _____

HEMNZRX-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
☐ **Neulasta®** (pegfilgrastim)	☐ 6 mg prefilled syringe	☐ Inject 6 mg (1 syringe) subcutaneously once per chemotherapy cycle ☐ Other: _____		
☐ **Neupogen®** (filgrastim)	☐ 300 mcg ☐ 480 mcg ☐ Prefilled syringe ☐ Vial	☐ Administer _____ mcg (____ mcg/kg/day x ____ kg) once a day for ____ days (Circle IV or SC)		
☐ **Nivestym™** (filgrastim-aafi)	☐ 300 mcg ☐ 480 mcg ☐ Prefilled syringe ☐ Vial	☐ Administer _____ mcg (____ mcg/kg/day x ____ kg) once a day for ____ days (Circle IV or SC)		
☐ **Procrit®** (epoetin alfa)	☐ 2,000 units/mL (SDV) ☐ 3,000 units/mL (SDV) ☐ 4,000 units/mL (SDV) ☐ 10,000 units/mL (SDV) ☐ 40,000 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: _____		
☐ **Retacrit™** (epoetin alfa-epbx)	☐ 2,000 units/mL (SDV) ☐ 3,000 units/mL (SDV) ☐ 4,000 units/mL (SDV) ☐ 10,000 units/mL (SDV) ☐ 40,000 units/mL (SDV)	☐ Single-dose Vial (SDV): Inject the entire contents of 1 vial subcutaneously ☐ Once a Week ☐ 3 Times a Week ☐ Other:_____ ☐ Other: _____		
☐ **Udenyca™** (pegfilgrastim-cbqv)	☐ 6 mg prefilled syringe	☐ Inject 6 mg (1 syringe) subcutaneously once per chemotherapy cycle (at least 24 hours after chemotherapy) ☐ Other: _____		
☐ **Zarxio™** (filgrastim-sndz)	☐ 300 mcg prefilled syringe ☐ 480 mcg prefilled syringe	☐ Administer _____ mcg (____ mcg/kg/day x ____ kg) once a day for ____ days (Circle IV or SC)		
☐ **Ziextenzo™** (pegfilgrastim-bmez)	☐ 6 mg prefilled syringe	☐ Inject 6 mg (1 syringe) subcutaneously once per chemotherapy cycle (at least 24 hours after chemotherapy) ☐ 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: _____ / _____ / _____