Thrombocytopenia Enrollment Form

PRx

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 #: ____

ITPRX-20-01

CLINICAL CONSIDERATIONS

Diagnosis:
☐ D69.3 Immune thrombocytopenic purpura (ITP)
☐ D61.9 Aplastic anemia, unspecified
☐ D61.3 Idiopathic aplastic anemia
☐ Other: ______________

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

Is patient new to therapy?: ☐ Yes ☐ No
Diagnosis Date: ____ /____ / ____

Immunization History
☐ Influenza
Date: ____ /____ / ____

Rx

Medication	Dose/Strength	Directions	Quantity	Refills
☐**Nplate®** (romiplostim)	☐ 125 mcg vial ☐ 250 mcg vial ☐ 500 mcg vial	☐ Inject _____mcg (1 mcg/kg x _____kg) subcutaneously once weekly ☐ Other:_______________________________________ (Patient Weight: ___ kg)		
☐**Promacta®** (eltrombopag)	☐ 12.5 mg tablet ☐ 25 mg tablet ☐ 50 mg tablet ☐ 75 mg tablet	☐ Take one tablet by mouth daily ☐ 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: ____ /____ / ____

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

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