



SPECIALTY PHARMACY

# BLOOD MODIFYING AGENTS

Lake Mary, FL toll free

toll free fax

krogerspecialtypharmacy.com

DATE: \_\_\_\_\_ NEEDS BY DATE: \_\_\_\_\_ SHIP TO: ☐ PATIENT ☐ OFFICE ☐ OTHER \_\_\_\_\_

PATIENT INFO		PRESCRIBER INFO	
Patient Name		Prescriber Name	
Address		DEA #	NPI # License #
City, State, Zip		Address	
Main Phone	Alternate Phone	City, State, Zip	
Social Security #		Phone	Fax
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Contact Person	

PLEASE FAX COPY OF: ☐ PRESCRIPTION CARD FRONT & BACK ☐ CLINICAL NOTES ☐ MEDICAL CARD FRONT & BACK

## CLINICAL INFORMATION

Primary Diagnosis

Secondary Diagnosis

 \_\_\_\_\_ ICD-10: \_\_\_\_\_  
 \_\_\_\_\_ ICD-10: \_\_\_\_\_

 \_\_\_\_\_ ICD-10: \_\_\_\_\_  
 \_\_\_\_\_ ICD-10: \_\_\_\_\_

Please Attach Supporting Labs and List of OTHER Medications

Drug Allergies: \_\_\_\_\_

PRESCRIPTION INFORMATION		DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Aranesp*	Vials: <input type="checkbox"/> 25 mcg <input type="checkbox"/> 40 mcg <input type="checkbox"/> 60 mcg <input type="checkbox"/> 100 mcg <input type="checkbox"/> 200 mcg <input type="checkbox"/> 300 mcg <input type="checkbox"/> 150 mcg/0.75 mL		_____	_____
	PFS: <input type="checkbox"/> 10 mcg/0.4 mL <input type="checkbox"/> 25 mcg/0.42 mL <input type="checkbox"/> 40 mcg/0.4 mL <input type="checkbox"/> 60 mcg/0.3 mL <input type="checkbox"/> 100 mcg/0.5 mL <input type="checkbox"/> 150 mcg/0.3 mL <input type="checkbox"/> 200 mcg/0.4 mL <input type="checkbox"/> 300 mcg/0.6 mL <input type="checkbox"/> 500 mcg/1 mL		_____	_____
<input type="checkbox"/> Epogen*	SDV: <input type="checkbox"/> 2,000 IU <input type="checkbox"/> 3,000 IU <input type="checkbox"/> 4,000 IU <input type="checkbox"/> 10,000 IU MDV: <input type="checkbox"/> 20,000 IU/2 mL <input type="checkbox"/> 20,000 IU /1 mL		_____	_____
<input type="checkbox"/> Granix*	PFS: <input type="checkbox"/> 300 mcg/0.5 mL <input type="checkbox"/> 480 mcg/0.8 mL		_____	_____
<input type="checkbox"/> Leukine*	<input type="checkbox"/> 250 mcg powder <input type="checkbox"/> 500 mcg vial		_____	_____
<input type="checkbox"/> Neulasta*	<input type="checkbox"/> 6 mg/0.6 mL PFS <input type="checkbox"/> Onpro kit		_____	_____
<input type="checkbox"/> Nplate*	<input type="checkbox"/> 250 mcg powder <input type="checkbox"/> 500 mcg powder		_____	_____
<input type="checkbox"/> Neupogen*	Vial: <input type="checkbox"/> 300 mcg/mL <input type="checkbox"/> 480 mcg/1.6 mL PFS: <input type="checkbox"/> 300 mcg/0.5 mL <input type="checkbox"/> 480 mcg/0.8 mL		_____	_____
<input type="checkbox"/> Procrit*	SDV: <input type="checkbox"/> 2,000 IU <input type="checkbox"/> 3,000 IU <input type="checkbox"/> 4,000 IU <input type="checkbox"/> 10,000 IU <input type="checkbox"/> 40,000 IU MDV: <input type="checkbox"/> 20,000 IU/2 mL <input type="checkbox"/> 20,000 IU /1 mL		_____	_____
<input type="checkbox"/> Promacta*	<input type="checkbox"/> 12.5 mg tab <input type="checkbox"/> 25 mg tab <input type="checkbox"/> 50 mg tab <input type="checkbox"/> 75 mg tab		_____	_____
<input type="checkbox"/> Zarxio*	PFS: <input type="checkbox"/> 300 mcg/0.5 mL <input type="checkbox"/> 480 mcg/0.8 mL		_____	_____
<input type="checkbox"/> Other	_____	_____	_____	_____

If not selected, Kroger Specialty Pharmacy will dispense insurance preferred. If you would like brand name, please write "MEDICALLY NECESSARY." By signing this form, Physician authorizes Kroger Specialty Pharmacy to act as his/her agent in the initiation and execution of patient's insurance PA process. \* All the supplies including syringes and needles will be dispensed if needed.

By signing this form and utilizing our services, you are authorizing Kroger Specialty Pharmacy™ and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (no stamps)

Substitution Permitted

Date

Prescriber's Signature (no stamps)

Dispense As Written

Date

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