BLOOD MODIFYING AGENTS

SPECIALTY PHARMACY

Irvine, CA toll free 855.313.9202 toll free fax 844.888.4157
krogerspecialtypharmacy.com

DATE: _____ NEEDS BY DATE: _____ SHIP TO: ❑ PATIENT ❑ OFFICE ❑ OTHER _____

PATIENT INFO

Patient Name

Address

City, State, Zip

Main Phone Alternate Phone

Social Security #

Date of Birth ❑ Male ❑ Female

PRESCRIBER INFO

Prescriber Name

DEA # NPI # License #

Address

City, State, Zip

Phone Fax

Contact Person

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

CLINICAL INFORMATION

Primary Diagnosis

_____ ICD-10: _____

_____ ICD-10: _____

Secondary Diagnosis

_____ ICD-10: _____

_____ ICD-10: _____

Please Attach Supporting Labs and List of OTHER Medications

Drug Allergies: _____

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