

Prescription & Enrollment Form
Neutropenia



677 Ala Moana Blvd., Suite 404,
 Honolulu, HI 96813-5412

**Four simple steps
 to submit your referral.**

1 PATIENT INFORMATION

New patient Current

Patient's first name _____
 Last name _____ Middle initial _____
 Date of birth _____ Male Female Last 4 digits of SSN _____
 Street address _____ Apt # _____
 City _____ State _____ Zip _____
 Parent/guardian (if applicable) _____
 Cell phone _____ Other phone _____
 E-mail address _____
 Patient's primary language: English Other If other, please specify _____

Please attach copies of front and back of patient's insurance cards or complete information below.

Insurance company _____ Phone _____
 Insured's name _____
 Insured's employer _____
 Relationship to patient _____
 Identification # _____
 Policy/group # _____
 Prescription card: Yes No If yes, carrier _____
 Policy # _____
 Group # _____
 Is patient eligible for Medicare? Yes No
 Does patient have a secondary insurance? Yes No

2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed: _____
 Deliver product to: Office Patient's home Clinic
 Prescriber's first name _____ Last name _____
 Prescriber's title _____
 If NP or PA, under direction of Dr. _____
 Office contact and title _____
 Office contact e-mail _____
 Office/clinic/institution name _____
 Clinic/hospital location _____
 Street address _____ Suite # _____
 City _____ State _____ Zip _____
 Phone _____ Fax _____
 NPI # _____ License # _____

3 CLINICAL INFORMATION

Primary ICD-10 code: _____ PRIMARY DIAGNOSIS _____
 Current weight _____ kg/lbs Height _____ inches/cm
 BSA _____ m² Date _____
 Laboratory results:
 WBC _____ cell/mm³ ANC _____ cell/mm³ Platelets _____ cell/mm³
 Date _____ Date _____ Date _____
 EXPECTED DATE OF FIRST/NEXT INJECTION _____
 DATE OF LAST INJECTION (if applicable) _____
 Agency nurse to visit home for injection: Yes No
 Agency name and phone _____
 NKDA Known drug allergies _____
 Concurrent meds _____

4 PRESCRIBING INFORMATION

Medication	Strength/Formulation	Directions	Quantity/Refills
<input type="checkbox"/> Granix® (tbo-filgrastim)	<input type="checkbox"/> 300mcg/0.5mL prefilled syringe <input type="checkbox"/> 480mcg/0.8mL prefilled syringe	Inject _____ mcg <input type="checkbox"/> IV <input type="checkbox"/> SC <input type="checkbox"/> Other _____ Dosing directions (include daily, weekly, cyclic, one-time, duration of therapy, etc.) Please include cycle. _____	Quantity _____ Days supply _____ Refills _____
<input type="checkbox"/> Leukine® (sargramostin) (liquid) <input type="checkbox"/> Leukine® (lyophilized)	<input type="checkbox"/> 500mcg/mL <input type="checkbox"/> 250mcg <input type="checkbox"/> 500mcg	Inject _____ mcg <input type="checkbox"/> IV <input type="checkbox"/> SC <input type="checkbox"/> Other _____ Dosing directions (include daily, weekly, cyclic, one-time, duration of therapy, etc.) Please include cycle. _____	Quantity _____ Days supply _____ Refills _____
<input type="checkbox"/> Neulasta® (pegfilgrastim) <input type="checkbox"/> Fulphila® (pegfilgrastim-jmdb) <input type="checkbox"/> Nyvepria™ (pegfilgrastim-apgf) <input type="checkbox"/> Udenyca™ (pegfilgrastim-cbqv) <input type="checkbox"/> Ziextenzo® (pegfilgrastim-bmez)	<input type="checkbox"/> 6mg/0.6mL prefilled syringe	Inject _____ mg subcutaneously Dosing directions (include post chemo directions, cyclic, one-time, duration of therapy, etc.) Please include cycle. _____	Quantity _____ Days supply _____ Refills _____
<input type="checkbox"/> Neulasta® Onpro (pegfilgrastim)	<input type="checkbox"/> 6mg/0.6mL subcutaneous prefilled syringe kit	To be applied by health care professional. Inject 6mg under the skin every _____ days as directed	Quantity _____ Days supply _____ Refills _____
<input type="checkbox"/> Neupogen® (filgrastim) <input type="checkbox"/> Nivestym™ (filgrastim-aafi)	<input type="checkbox"/> 300mcg/mL vial <input type="checkbox"/> 300mcg/0.5mL prefilled syringe <input type="checkbox"/> 480mcg/1.6mL vial <input type="checkbox"/> 480mcg/0.8mL prefilled syringe	Inject _____ mcg <input type="checkbox"/> IV <input type="checkbox"/> SC <input type="checkbox"/> Other _____ Dosing directions (include daily, weekly, cyclic, one-time, duration of therapy, etc.) Please include cycle. _____	Quantity _____ Days supply _____ Refills _____
<input type="checkbox"/> Zarxio™ (filgrastim-sndz) <input type="checkbox"/> Other _____	<input type="checkbox"/> 300mcg/0.5mL prefilled syringe <input type="checkbox"/> 480mcg/0.8mL prefilled syringe	Inject _____ mcg <input type="checkbox"/> IV <input type="checkbox"/> SC <input type="checkbox"/> Other _____ Dosing directions (include daily, weekly, cyclic, one-time, duration of therapy, etc.) Please include cycle. _____	Quantity _____ Days supply _____ Refills _____
Supplies (if needed per dose): <input type="checkbox"/> 1mL syringe <input type="checkbox"/> 22G 1" mixing needle <input type="checkbox"/> 25G 5/8" admin. needle <input type="checkbox"/> 3mL syringe <input type="checkbox"/> Sterile water 10mL <input type="checkbox"/> 27 1/2G 5/8" admin. needle (pediatrics only)			Send quantity sufficient for medication days supply
<input type="checkbox"/> Prescriber, please check here to authorize ancillary supplies such as needles, syringes, sterile water, etc. to administer the therapy		As needed for administration	Send quantity sufficient for medication days supply

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

By signing below, I certify that the above therapy is medically necessary. I also authorize Accredo to initiate any de minimus authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans, to the extent not prohibited.

Prescriber's signature (sign below) (Physician attests this is his/her legal signature. **NO STAMPS**)

PHYSICIAN SIGNATURE REQUIRED

Date _____ Dispense as written _____ Date _____ Substitution allowed _____
 The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

Please fax completed form to the Neutropenia team at 808.650.6487. To reach your team, call toll-free 808.650.6488.

You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

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