Please fax both pages of completed form to your Neutropenia team at 888.302.1028.

To reach your team, call toll-free 844.516.3319.

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

Prescription & Enrollment Form

Neutropenia

Four simple steps to submit your referral.

1 Patient Information

Please attach copies of front and back of patient's insurance cards.

❑ New patient ❑ Current patient

Patient's first name ______ Last name ______ Middle initial ______

❑ Male ❑ Female Last 4 digits of SSN ______ Date of birth ______

Street address ______ Apt # ______

City ______ State ______ Zip ______

Parent/guardian (if applicable) ______

Home phone ______ Cell phone ______ E-mail address ______

Alternate caregiver/contact ______

Home phone ______ Cell phone ______ E-mail address ______

❑ OK to leave message with alternate caregiver/contact

Patient's primary language: ❑ English ❑ Other If other, please specify ______

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date ______ Time ______ Date medication needed ______

Prescriber's first name ______ Last name ______

Prescriber's title ______ If NP or PA, under direction of Dr. ______

Office address ______

Office contact and title ______

Office contact phone number ______ Office contact e-mail ______

Office/Infusion clinic name ______ Office/Infusion clinic affiliation ______

Street address ______ Suite # ______

City ______ State ______ Zip ______

Phone ______ Fax ______ NPI # ______ License # ______

Deliver product to: ❑ Office ❑ Clinic ❑ Patient's home

Clinic location ______

3 Clinical Information

Primary ICD-10 code: ______ PRIMARY DIAGNOSIS ______

Current weight ______ kg/lbs Height ______ inches/cm BSA ______ m^2 Date measured ______

Laboratory results: WBC ______ cell/mm^3 ANC ______ cell/mm^3 Platelets ______ cell/mm^3

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 ______

Fax completed form to 888.302.1028.

Patient's first name ______________________ Last name _________________________ Middle initial ______ Date of birth __________

Prescriber's first name ______________________________ Last name ________________________________ Phone ________________

4 Prescribing Information

Medication	Strength/Formulation	Directions	Quantity/Refills
❑ Granix® (tbo-filgrastim)	❑ 300mcg/mL vial ❑ 300mcg/0.5mL prefilled syringe ❑ 480mcg/1.6mL vial ❑ 480mcg/0.8mL prefilled syringe	Inject _______ mcg ❑ SC ❑ Other _________________ Dosing directions (include daily, weekly, cyclic, one-time, duration of therapy, etc.) **Please include cycle.** _____________________________	Quantity ________________ Days supply ______________ Refills __________________
❑ Leukine® (sargramostim) (liquid) ❑ Leukine® (lyophilized)	❑ 500mcg/mL ❑ 250mcg ❑ 500mcg	Inject _______ mcg ❑ IV ❑ SC ❑ Other ______________ Dosing directions (include daily, weekly, cyclic, one-time, duration of therapy, etc.) **Please include cycle.** _____________________________	Quantity ________________ Days supply ______________ Refills __________________
❑ Neulasta® (pegfilgrastim)	❑ 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 __________________
❑ Neulasta® Onpro (pegfilgrastim)	❑ 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 __________________
❑ Neupogen® (filgrastim) ❑ Nivestym™ (filgrastim-aafi)	❑ 300mcg/mL vial ❑ 300mcg/0.5mL prefilled syringe ❑ 480mcg/1.6mL vial ❑ 480mcg/0.8mL prefilled syringe	Inject _______ mcg ❑ IV ❑ SC ❑ Other ______________ Dosing directions (include daily, weekly, cyclic, one-time, duration of therapy, etc.) **Please include cycle.** _____________________________	Quantity ________________ Days supply ______________ Refills __________________
❑ Zarxio™ (filgrastim-sndz)	❑ 300mcg/0.5mL prefilled syringe ❑ 480mcg/0.8mL prefilled syringe	Inject _______ mcg ❑ SC ❑ Other _________________ Dosing directions (include daily, weekly, cyclic, one-time, duration of therapy, etc.) **Please include cycle.** _____________________________	Quantity ________________ Days supply ______________ Refills __________________
❑ Other ________________ ______________________			
Supplies (if needed per dose): ❑ 1mL syringe ❑ 22G 1" mixing needle ❑ 25G 5/8" admin. needle ❑ 3mL syringe ❑ Sterile water 10mL ❑ 27 1/2G 5/8" admin. needle (pediatrics only)			Send quantity sufficient for medication days supply
❑ 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 or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.

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

PHYSICIAN SIGNATURE REQUIRED

SIGN HERE

________________ ______________________________ ________________ ______________________________
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.

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