elixir
SPECIALTY PHARMACY

Hematopoietic/GCSF Enrollment Form

Phone: 877-437-9012 Fax: 877-309-0687

☐ New to Therapy
☐ Current Therapy

Patient Information

Patient Name: _____
Date of Birth: _____ Sex: M or F Caregiver:_____
Address: _____
City: _____ State:_____ Zip:_____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-mail:_____
Please attach copy of front and back of patient's prescription ins. card(s) if applicable
Insurance Company Name: _____
Insurance Company Phone: _____
Policy Holder:_____
Policy Holder Employer:_____
Relationship to Patient:_____
ID#:_____Group#:_____
RxBIN: _____RxPCN:_____

Prescriber Information

Practice/ Organization Name: _____
Prescriber Name:_____
Address:_____
City: _____State: _____ Zip: _____
Phone#:_____Fax#:_____
DEA#:_____ NPI#: _____
License#:_____Medicaid UPIN#:_____
Physician Specialty: _____
Date Shipment Needed: _____
Ship to: ☐ Patient ☐ Prescriber ☐ Other:_____
Shipment Address: _____ Attn: _____
City: _____ State: _____ Zip:_____
If shipped to the prescriber's office, Prescriber accepts on behalf of patient for administration in office.

Clinical Information and Prescription

Primary Diagnosis (ICD10): ☐ _ _ _ . _ _ Description: _____
Secondary Diagnosis (ICD10): ☐ _ _ _ . _ _ Description: _____
Date of Diagnosis or Years with Disease: _____
Patients Allergies: _____
Latex allergy: ☐Yes ☐No Patient Weight: _____ Patient Height: _____
Medical History - **Please attach all lab/test results/treatment plans**

Hemaglobin	Lab Date	Hematocrit	Lab Date	Platelets	Lab Date
%	/ /	g/dl	/ /		/ /
WBC	Lab Date	ANC	Lab Date	Ferritin	Lab Date
cells/mm³	/ /	cells/mm³	/ /		/ /

Comorbidities: _____
Expected First Dose Date: _____ Injection Instruction needed: ☐ Yes ☒No

☐ **Aranesp® (darbepoetin alfa)**
Single Dose Vial: ☐ 25 mcg/ml ☐ 40 mcg/ml ☐ 60 mcg/ml ☐ 100 mcg/ml ☐ 150 mcg/0.75 ml ☐ 200 mcg/ml ☐ 300 mcg/ml
SingleJect® PFS: ☐10 mcg/0.4 ml ☐ 25 mcg/0.42ml ☐ 40 mcg/0.4ml ☐60 mcg/0.3ml ☐100 mcg/0.5ml ☐150 mcg/0.3 ml ☐ 200 mcg/0.4ml ☐ 300 mcg/0.6ml ☐ 500 mcg/ml

☐ **Epogen® (epoetin alfa) OR ☐ Procrit® (epoetin alfa) OR ☐ Retacrit® (epoetin alfa-epbx)**
☐ 2,000 units ☐ 3,000 units ☐ 4,000 units ☐ 10,000 units
☐ 20,000 units (Epogen and Procrit only) ☐ 40,000 units (Procrit and Retacrit only)

☐ **Leukine® (sargramostin)** ☐ 250mcg lypholized powder for inj ☐ 500mcg soln for inj

☐ **Neulasta®(pegfilgrastim) OR ☐ Fulphila® (pegfil-jmdb) OR ☐ Nyvepria® (pegfil-apgf) OR ☐ Udenyca® (pegfil-cbqv) OR ☐ Ziextenzo® (pegfil-bmez)**
☐ 0.6mg/0.6ml Prefilled Syringe ☐ 0.6mg/0.6ml Onpro Injection Kit (Neulasta only)

☐ **Neupogen® (filgrastim) OR ☐ Zarxio® (filgrastim-sndz) OR ☐ Granix® (Tbo-filgrastim) OR ☐ Nivestym® (filgrastim-aafi)**
☐ 300 mcg/0.5ml Prefilled Syringe ☐ 300 mcg/ml vial (Not available with Zarxio)
☐ 480 mcg/0.8ml Prefilled Syringe ☐ 480 mcg/1.6ml vial (Not available with Zarxio)

☐ **Promacta® (eltrombopag)** ☐12.5 mg tablets ☐25 mg tablets ☐50 mg tablets ☐75 mg tablets

Dose: Inject _____ mcg/kg or ____ mcg/m2 via ☐ IV ☐ Subcutaneously ☐ Continuous SC
Directions: _____
Quantity: ☐ QS 30 days ☐ Other: ___ Refills Authorized:☐ 0 ☐ 1 ☐ 3 ☐ 6 ☐ 11 ☐ Other: _____
Prescriber Signature: *X*_____ Date: ____/____/____