Neutropenia

PRESCRIPTION & ENROLLMENT FORM

☐ New Patient
☐ Current

1 PATIENT INFORMATION

Patient's Name _____

Date of Birth _____ ☐ Male ☐ Female Last 4 digits of SSN_____

Street Address _____ Apt#_____

City _____ State _____ Zip _____

Parent/Guardian (if applicable) _____

Home Phone _____ Work Phone _____

Cell Phone _____ Evening Phone _____

E-mail address _____

Insurance Company Name _____

Insurance Company Phone No. _____

Insured's Name _____

Insured's Employer _____

Relationship to Patient _____

Identification No._____ Policy/Group No. _____

Prescription Card ☐ No ☐ Yes If Yes, Carrier _____

Policy No. _____ Group No. _____

Is patient eligible for Medicare? ☐ No ☐ Yes **Please attach front and back copy of patient's insurance cards, if available.**

2 PRESCRIBER INFORMATION

Prescriber's Name _____

Office Contact _____

Clinic / Hospital Affiliation _____

Street Address_____Suite # _____

City _____ State _____ Zip _____

Phone _____ Fax _____

NPI No. _____ License No._____

DEA No. _____

Physician Medicaid UPIN No._____

MD Specialty _____

Fax Referral to 718-360-9655 Or call 718-556-0942

Enexia Specialty

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 & Phone:_____

_____

Rx: Leukine® (sargramostin) (liquid) ☐ 500 mcg/ml

(lyophilized) ☐ 250 mcg ☐ 500 mcg

Neulasta® (pegfilgrastim) ☐ 6 mg/0.6 ml prefilled Syringe

Neupogen® (filgrastim) ☐ 300 mcg/ml vial ☐ 300mcg/0.5 prefilled Syringe

☐ 480 mcg/ml vial ☐ 480mcg/0.8 prefilled Syringe

SIG: Inject Dose: _____ mcg/kg or _____mcg/m2

Route: ☐ IV ☐ SC ☐ Continuous SC

Dosing Directions(Include daily, weekly, cyclic, one-time, duration of txt. etc.)

_____

_____

Dispense Quantity:_____ Refills:_____

Supplies (if needed per dose): ☐1 ml syringe ☐3 ml syringe

☐ 22G 1" mixing needle ☐ Sterile Water 10 ml

☐ 25G 5/8" admin. needle ☐ 271/2G 5/8"admin. needle (Pediatrics Only)

☐ NKDA ☐ Known Drug Allergies:_____

_____

Deliver product to: ☐Office ☐ Patient's Home ☐ Clinic Clinic Location

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.

Prescriber's Printed Name _____

Prescriber's Signature (sign below) **Date** _____

_____ _____

Dispense as Written **Substitution Allowed**

(Physician attests this is his/her legal signature. **NO STAMPS)**