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: __________ Gender: _________ SS#__________________
Address: ______________________________
City: ____________________State: ________Zip: ________________
Home Phone: __________________ Work Phone: ________________
Cell Phone: ________________ E-mail:__________________________
Patient Weight: _________ kg/ lbs Patient Height: __________ in/ cm
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#: _______________
Prescriber Specialty: ______________________________
Date Shipment Needed: ______________________________
Ship to: ☐ **Patient** ☐ **Prescriber** ☐ **Other:** __________________
Shipment Address: ______________________________
City: ____________________State: __________ Zip: ______________

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

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Clinical Information and Prescription

Primary Diagnosis (ICD-10):_______________Description:_____________________________
Secondary Diagnosis (ICD-10):_____________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/mm²	/ /	cells/mm²	/ /		/ /

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/0.75mL ☐200 mcg/mL ☐300 mcg/mL
SingleJect® PFS ☐10 mcg/0.4mL ☐25 mcg/0.42mL ☐40 mcg/0.4mL ☐60 mcg/0.3mL ☐100 mcg/0.5mL ☐150 mcg/0.4mL ☐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 injection ☐500mcg solution for injection

☐**Neulasta® (pegfilgrastim) OR** ☐**Fulphila® (pegfil-jmdb) OR** ☐**Nyvepria® (pegfil-apgf) OR** ☐**Udenyca® (pegfil-cbqv) OR** ☐ **Ziextenzo® (pegfil-bmez)**
☐ 0.6 mg/0.6mL Prefilled Syringe ☐0.6 mg/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 availabaile with Zarxio)
☐480 mcg/0.8mL Prefilled Syringe ☐480 mcg/1.6mL vial (Not available with Zarxio)

☐**Promacta® (eltrombopag)** ☐12.5 mg tablet ☐25 mg tablet ☐60 mg tablet ☐75 mg tablet

Dose: Inject_________mcg/kg or ________mcg/m² via ☐IV ☐Subcutaneously ☐Continuous SC
Directions:______________________________
Quantity:________________________Refills Authorized: ☐ 0 ☐ 1 ☐ 3 ☐ 6 ☐ 11 ☐Other:_______
Prescriber Signature: X __________________ Date:____/____/____

If Brand required "Dispense as Written" Must be hand written

Updated Sept 2023