



SPECIALTY PHARMACY

# BLOOD MODIFYING AGENTS

Irvine, CA toll free 855.313.9202 toll free fax 844.888.4157

[krogerspecialtypharmacy.com](http://krogerspecialtypharmacy.com)

DATE: \_\_\_\_\_ NEEDS BY DATE: \_\_\_\_\_ SHIP TO:  PATIENT  OFFICE  OTHER \_\_\_\_\_

PATIENT INFO	
Patient Name	
Address	
City, State, Zip	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female

PRESCRIBER INFO		
Prescriber Name		
DEA #	NPI #	License #
Address		
City, State, Zip		
Phone	Fax	
Contact Person		

PLEASE FAX COPY OF:  PRESCRIPTION CARD FRONT & BACK  CLINICAL NOTES  MEDICAL CARD FRONT & BACK

## CLINICAL INFORMATION

Primary Diagnosis	Secondary Diagnosis
_____ ICD-10: _____	_____ ICD-10: _____
_____ ICD-10: _____	_____ ICD-10: _____

Please Attach Supporting Labs and List of OTHER Medications

Drug Allergies: \_\_\_\_\_

PRESCRIPTION INFORMATION		DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Aranesp*	Vials: <input type="checkbox"/> 25 mcg <input type="checkbox"/> 40 mcg <input type="checkbox"/> 60 mcg <input type="checkbox"/> 100 mcg <input type="checkbox"/> 200 mcg <input type="checkbox"/> 300 mcg <input type="checkbox"/> 150 mcg/0.75 mL PFS: <input type="checkbox"/> 10 mcg/0.4 mL <input type="checkbox"/> 25 mcg/0.42 mL <input type="checkbox"/> 40 mcg/0.4 mL <input type="checkbox"/> 60 mcg/0.3 mL <input type="checkbox"/> 100 mcg/0.5 mL <input type="checkbox"/> 150 mcg/0.3 mL <input type="checkbox"/> 200 mcg/0.4 mL <input type="checkbox"/> 300 mcg/0.6 mL <input type="checkbox"/> 500 mcg/1 mL		_____	_____
<input type="checkbox"/> Epogen*	SDV: <input type="checkbox"/> 2,000 IU <input type="checkbox"/> 3,000 IU <input type="checkbox"/> 4,000 IU <input type="checkbox"/> 10,000 IU MDV: <input type="checkbox"/> 20,000 IU/2 mL <input type="checkbox"/> 20,000 IU /1 mL		_____	_____
<input type="checkbox"/> Granix*	PFS: <input type="checkbox"/> 300 mcg/0.5 mL <input type="checkbox"/> 480 mcg/0.8 mL		_____	_____
<input type="checkbox"/> Leukine*	<input type="checkbox"/> 250 mcg powder <input type="checkbox"/> 500 mcg vial		_____	_____
<input type="checkbox"/> Neulasta*	<input type="checkbox"/> 6 mg/0.6 mL PFS <input type="checkbox"/> Onpro kit		_____	_____
<input type="checkbox"/> Nplate*	<input type="checkbox"/> 250 mcg powder <input type="checkbox"/> 500 mcg powder		_____	_____
<input type="checkbox"/> Neupogen*	Vial: <input type="checkbox"/> 300 mcg/mL <input type="checkbox"/> 480 mcg/1.6 mL PFS: <input type="checkbox"/> 300 mcg/0.5 mL <input type="checkbox"/> 480 mcg/0.8 mL		_____	_____
<input type="checkbox"/> Procrit*	SDV: <input type="checkbox"/> 2,000 IU <input type="checkbox"/> 3,000 IU <input type="checkbox"/> 4,000 IU <input type="checkbox"/> 10,000 IU <input type="checkbox"/> 40,000 IU MDV: <input type="checkbox"/> 20,000 IU/2 mL <input type="checkbox"/> 20,000 IU /1 mL		_____	_____
<input type="checkbox"/> Promacta*	<input type="checkbox"/> 12.5 mg tab <input type="checkbox"/> 25 mg tab <input type="checkbox"/> 50 mg tab <input type="checkbox"/> 75 mg tab		_____	_____
<input type="checkbox"/> Zarxio*	PFS: <input type="checkbox"/> 300 mcg/0.5 mL <input type="checkbox"/> 480 mcg/0.8 mL		_____	_____
<input type="checkbox"/> Other	_____	_____	_____	_____

If not selected, Kroger Specialty Pharmacy will dispense insurance preferred. If you would like brand name, please write "MEDICALLY NECESSARY." By signing this form, Physician authorizes Kroger Specialty Pharmacy to act as his/her agent in the initiation and execution of patient's insurance PA process. \* All the supplies including syringes and needles will be dispensed if needed.

By signing this form and utilizing our services, you are authorizing Kroger Specialty Pharmacy™ and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (no stamps)      Substitution Permitted      Date      Prescriber's Signature (no stamps)      Dispense As Written      Date

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