



BLOOD MODIFYING AGENTS

Irvine, CA toll free 855.313.9202 toll free fax 844.888.4157

krogerspecialtypharmacy.com

SPECIALTY PHARMACY

DATE: _____ NEEDS BY DATE: _____ SHIP TO: PATIENT OFFICE OTHER _____

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

PRESCRIBER INFORMATION		
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: _____ ICD-10: _____ Secondary Diagnosis: _____ 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"/> 25mcg <input type="checkbox"/> 40mcg <input type="checkbox"/> 60mcg <input type="checkbox"/> 100mcg <input type="checkbox"/> 200mcg <input type="checkbox"/> 300mcg PFS: <input type="checkbox"/> 10mcg/0.4mL <input type="checkbox"/> 25mcg/0.42mL <input type="checkbox"/> 40mcg/0.4mL <input type="checkbox"/> 60mcg/0.3mL <input type="checkbox"/> 100mcg/0.5mL <input type="checkbox"/> 150mcg/0.3mL <input type="checkbox"/> 200mcg/0.4mL <input type="checkbox"/> 300mcg/0.6mL <input type="checkbox"/> 500mcg/1mL		_____	_____
<input type="checkbox"/> Doptelet®	<input type="checkbox"/> 20mg tablet Procedure Date (for Chronic Liver Disease-associated thrombocytopenia): _____		_____	_____
<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/2mL <input type="checkbox"/> 20,000 IU/1mL		_____	_____
<input type="checkbox"/> Granix®	PFS: <input type="checkbox"/> 300mcg/0.5mL <input type="checkbox"/> 480mcg/0.8mL		_____	_____
<input type="checkbox"/> Leukine®	<input type="checkbox"/> 250mcg powder		_____	_____
<input type="checkbox"/> Neulasta®	<input type="checkbox"/> 6mg/0.6mL PFS <input type="checkbox"/> Onpro kit		_____	_____
<input type="checkbox"/> Nplate®	<input type="checkbox"/> 250mcg powder <input type="checkbox"/> 500mcg powder		_____	_____
<input type="checkbox"/> Neupogen®	Vial: <input type="checkbox"/> 300mcg/mL <input type="checkbox"/> 480mcg/1.6mL PFS: <input type="checkbox"/> 300mcg/0.5mL <input type="checkbox"/> 480mcg/0.8mL		_____	_____
<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/2mL <input type="checkbox"/> 20,000 IU/1mL		_____	_____
<input type="checkbox"/> Promacta®	<input type="checkbox"/> 12.5mg tablet <input type="checkbox"/> 25mg tablet <input type="checkbox"/> 50mg tablet <input type="checkbox"/> 75mg tablet		_____	_____
<input type="checkbox"/> Zarxio®	PFS: <input type="checkbox"/> 300mcg/0.5mL <input type="checkbox"/> 480mcg/0.8mL		_____	_____
<input type="checkbox"/> Other			_____	_____

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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