SPECIALTY PHARMACY

BLOOD MODIFYING AGENTS

Lake Mary, FL toll free 888.506.2962 toll free fax 888.315.3270
krogerspecialtypharmacy.com

DATE: _______________ NEEDS BY DATE: _______________ SHIP TO: ❑ PATIENT ❑ OFFICE ❑ OTHER ______________________________

PATIENT INFORMATION			PRESCRIBER INFORMATION		
Patient Name			Prescriber Name		
Address			DEA #	NPI #	License #
City, State, Zip			Address		
Main Phone	Alternate Phone		City, State, Zip		
Social Security #			Phone	Fax	
Date of Birth	❑ Male	❑ Female	Contact Person		

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

CLINICAL INFORMATION

Primary Diagnosis:

______________________________ ICD-10: ______________

______________________________ ICD-10: ______________

Secondary Diagnosis:

______________________________ ICD-10: ______________

______________________________ ICD-10: ______________

Please Attach Supporting Labs and List of OTHER Medications

Drug Allergies: ____

PRESCRIPTION INFORMATION		DIRECTIONS	QUANTITY	REFILLS
❑ Aranesp®	Vials: ❑ 25mcg ❑ 40mcg ❑ 60mcg ❑ 100mcg ❑ 200mcg ❑ 300mcg PFS: ❑ 10mcg/0.4mL ❑ 25mcg/0.42mL ❑ 40mcg/0.4mL ❑ 60mcg/0.3mL ❑ 100mcg/0.5mL ❑ 150mcg/0.3mL ❑ 200mcg/0.4mL ❑ 300mcg/0.6mL ❑ 500mcg/1mL		________ ________	________ ________
❑ Doptelet®	❑ 20mg tablet Procedure Date *(for Chronic Liver Disease-associated thrombocytopenia)*: ____________		________	________
❑ Epogen®	SDV: ❑ 2,000 IU ❑ 3,000 IU ❑ 4,000 IU ❑ 10,000 IU MDV: ❑ 20,000 IU/2mL ❑ 20,000 IU/1mL		________	________
❑ Granix®	PFS: ❑ 300mcg/0.5mL ❑ 480mcg/0.8mL		________	________
❑ Leukine®	❑ 250mcg powder		________	________
❑ Neulasta®	❑ 6mg/0.6mL PFS ❑ Onpro kit		________	________
❑ Nplate®	❑ 250mcg powder ❑ 500mcg powder		________	________
❑ Neupogen®	Vial: ❑ 300mcg/mL ❑ 480mcg/1.6mL PFS: ❑ 300mcg/0.5mL ❑ 480mcg/0.8mL		________	________
❑ Procrit®	SDV: ❑ 2,000 IU ❑ 3,000 IU ❑ 4,000 IU ❑ 10,000 IU ❑ 40,000 IU MDV: ❑ 20,000 IU/2mL ❑ 20,000 IU/1mL		________	________
❑ Promacta®	❑ 12.5mg tablet ❑ 25mg tablet ❑ 50mg tablet ❑ 75mg tablet		________	________
❑ Zarxio®	PFS: ❑ 300mcg/0.5mL ❑ 480mcg/0.8mL		________	________
❑ 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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