HEMATOLOGY REFERRAL FORM A – M

Albertsons Companies Specialty Care | MEDCART SPECIALTY PHARMACY | Jewel Osco | Albertsons | SAFEWAY | VONS | ACME | shaw's | star market | PAVILIONS | CARRS | Randalls | Tom Thumb

Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F

Phone: _____ Cell Phone: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

ICD-10 Diagnosis Code: _____ Diagnosis: _____

Allergies (please note reaction): _____ ☐ Latex

Current Medications: (list here or attach a medication list): _____

_____

Comorbidities: (list here or attach a list): _____

Prescription Information

INSURANCE INFORMATION – FAX COPY OF PATIENT'S INSURANCE CARD – BOTH SIDES

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Aranesp (darbepoetin alfa)	☐ 25mcg/mL Single Dose Vial ☐ 40mcg/mL Single Dose Vial ☐ 60mcg/mL Single Dose Vial ☐ 100mcg/mL Single Dose Vial ☐ 200mcg/mL Single Dose Vial ☐ 300mcg/mL Single Dose Vial ☐ 10mcg/0.4mL Prefilled Syringe ☐ 25mcg/0.4mL Prefilled Syringe ☐ 40mcg/0.4mL Prefilled Syringe ☐ 60mcg/0.3mL Prefilled Syringe ☐ 100mcg/0.5mL Prefilled Syringe ☐ 150 mcg/0.3mL Prefilled Syringe ☐ 200mcg/0.4mL Prefilled Syringe ☐ 300mcg/0.6mL Prefilled Syringe ☐ 500mcg/mL Prefilled Syringe			
☐ Epogen (epoetin alfa)	☐ 2,000 units/mL Single Dose Vial ☐ 3,000 units/mL Single Dose Vial ☐ 4,000 units/mL Single Dose Vial ☐ 10,000 units/mL Single Dose Vial ☐ 20,000 units/mL Single Dose Vial ☐ 40,000 units/mL Single Dose Vial			

Treatment History: ☐ New to Therapy ☐ Continuation of Therapy

Prescriber Information

Prescriber Name: _____

State License #: _____ DEA #: _____ NPI: _____

Additional Contact Person Name: _____

Group or Hospital: _____ Phone: _____

Fax: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Prescriber Signature: _____ Product Substitution Permitted _____ Dispensed as Written _____ Date

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Delivery Information

☐ Ship to Patient ☐ Ship to Prescriber/Clinic ☐ Pick up at Albertsons Companies Pharmacy ☐ Pharmacist may Administer

Date Medication Needed: _____

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HEMATOLOGY REFERRAL FORM N

Albertsons Companies Specialty Care | MEDCART SPECIALTY PHARMACY | Jewel Osco. | Albertsons | SAFEWAY | VONS | ACME | shaw's | star market | PAVILIONS | CARRS | Randalls | Tom Thumb

Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F

Phone: _____ Cell Phone: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

ICD-10 Diagnosis Code: _____ Diagnosis: _____

Allergies (please note reaction): _____ ☐ Latex

Current Medications: (list here or attach a medication list): _____

_____

Comorbidities: (list here or attach a list): _____

Prescription Information

INSURANCE INFORMATION – FAX COPY OF PATIENT'S INSURANCE CARD – BOTH SIDES

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Neulasta (pegfilgrastim)	☐ 6mg/0.6mL Onpro Kit ☐ 6mg/0.6mL Prefilled Syringe	☐ Inject 6mg subcutaneously once per chemotherapy cycle, beginning at least 24 hours after completion of chemotherapy. ☐ Other:		
☐ Neupogen (filgrastim)	☐ 300mcg/mL Single Dose Vial ☐ 480mcg/1.6mL Single Dose Vial ☐ 300mcg/0.5mL Prefilled Syringe ☐ 480mcg/0.8mL Prefilled Syringe			
☐ Nplate	☐ 125mcg ☐ 250mcg ☐ 500mcg	•Administer ____ mcg (1mcg/kg actual body weight) subcutaneously once weekly. •Adjust the dose as follows for adult patients: ☐ If the platelet count is < 50 × 109 /L, increase the dose by 1 mcg/kg. ☐ If platelet count is > 200 × 109 /L and ≤ 400 × 109 /L for 2 consecutive weeks, reduce the dose by 1 mcg/kg. ☐ If platelet count is > 400 × 109 /L, do not dose. Continue to assess the platelet count weekly. ☐ After the platelet count has fallen to < 200 × 109 /L, resume Nplate at a dose reduced by 1 mcg/kg. •Adjust the dose as follows for pediatric patients: ☐ If the platelet count is < 50 × 109 /L, increase the dose by 1 mcg/kg. ☐ If platelet count is > 200 × 109 /L and ≤ 400 × 109 /L for 2 consecutive weeks, reduce the dose by 1 mcg/kg. ☐ If platelet count is > 400 × 109 /L, do not dose. Continue to assess the platelet count weekly. ☐ After the platelet count has fallen to < 200 × 109 /L, resume Nplate at a dose reduced by 1 mcg/kg.		

Treatment History: ☐ New to Therapy ☐ Continuation of Therapy

Prescriber Information

Prescriber Name: _____

State License #: _____ DEA #: _____ NPI: _____

Additional Contact Person Name: _____

Group or Hospital: _____ Phone: _____

Fax: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Prescriber Signature: _____ _____ _____

Product Substitution Permitted | Dispensed as Written | Date

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Delivery Information

☐ Ship to Patient ☐ Ship to Prescriber/Clinic ☐ Pick up at Albertsons Companies Pharmacy Date Medication Needed: _____

HEMATOLOGY REFERRAL FORM O – Z

Albertsons Companies Specialty Care | MEDCART SPECIALTY PHARMACY | Jewel Osco | Albertsons | SAFEWAY | VONS | ACME | shaw's | star market | PAVILIONS | CARRS | Randalls | Tom Thumb

Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F

Phone: _____ Cell Phone: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

ICD-10 Diagnosis Code: _____ Diagnosis: _____

Allergies (please note reaction): _____ ☐ Latex

Current Medications: (list here or attach a medication list): _____

_____

Comorbidities: (list here or attach a list): _____

Prescription Information

INSURANCE INFORMATION – FAX COPY OF PATIENT'S INSURANCE CARD – BOTH SIDES

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Procrit (epoetin alfa)	☐ 10,000 units/mL Multidose Vial ☐ 20,000 units/mL Multidose Vial ☐ 2,000 units/mL Single Dose Vial ☐ 3,000 units/mL Single Dose Vial ☐ 4,000 units/mL Single Dose Vial ☐ 10,000 units/mL Single Dose Vial ☐ 40,000 units/mL Single Dose Vial			
☐ Promacta (eltrombopag)	☐ 12.5mg Tablet ☐ 25mg Tablet ☐ 50mg Tablet ☐ 75mg Tablet	☐ Take 1 tablet by mouth once daily. ☐ Other:		
☐ Zarxio (filgrastim-sndz)	☐ 300mcg/0.5mL Prefilled Syringe ☐ 480mcg/0.8mL Prefilled Syringe			
Other Medication Name:				

Treatment History: ☐ New to Therapy ☐ Continuation of Therapy

Prescriber Information

Prescriber Name: _____

State License #: _____ DEA #: _____ NPI: _____

Additional Contact Person Name: _____

Group or Hospital: _____ Phone: _____

Fax: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Prescriber Signature: _____ Product Substitution Permitted _____ Dispensed as Written _____ Date

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Delivery Information

☐ Ship to Patient ☐ Ship to Prescriber/Clinic ☐ Pick up at Albertsons Companies Pharmacy Date Medication Needed: _____