Hematopoietic Growth Factors
In Oncology
Enrollment Form

Phone: 1-844-309-7171
Fax: 1-844-309-7173

1. PATIENT INFORMATION

Patient Name	☐ Male ☐ Female	Allergies ☐ NKDA	
Date of Birth	SSN#	Weight _____kg/ lb Height _____cm/ in	
Address	City	State	Zip
Phone # (Home)	(Work)	Email address(optional)	

2. INSURANCE INFORMATION

Primary Insurance	RX Ins: BIN_____ PCN_____	Policyholder
Group #	Policy #	Phone #
Secondary Insurance	Policy #	Phone #

3. DIAGNOSIS/MEDICAL INFORMATION (PLEASE ANSWER ALL QUESTIONS TO PREVENT A DELAY IN PATIENT'S THERAPY.)

☐ 288.0 Agranulocytosis (Neutropenia)	☐ 205.0 Acute Myeloid Leukemia	☐ 204.0 Acute lymphoid leukemia
☐ 238.7 Other lymphatic and hematopoietic tissues	☐ 996.85 Complications of transplanted organ – none marrow	Other ICD-9 _____

Absolute neutrophil count : _____ / mm^3 _____ date | WBC _____cells / mm^3 _____ date

Prophylaxis for neutropenia only, does the patient meet one of the following criteria? ☐ yes ☐ no

- Patient at intermediate to high risk (> 10% risk) of febrile neutropenia given chemotherapy regimen OR
- Patient with risk factors (treatment-related, patient-related, cancer-related, conditions associated with risk of serious infection, comorbities) that are associated with an increased risk of neutropenia

4. PRESCRIPTION INFORMATION

Medication	Dosage		Quantity	Refills
☐ Neulasta® (Pegfilgrastim)	☐ 6 mg SQ once every _____days		_____# 10 mg/mL syringes	
☐ Neupogen® (Filgrastim)	☐ 300 mcg/ mL vial ☐ 480 mcg/ 1.6 mL vial ☐ 300 mcg/ 0.5 mL PFS ☐ 480 mcg/ 0.8 mL PFS	☐ 5 mcg/kg SQ daily for _____days ☐ _____ (Please fill in weight section)	_____# Vials _____# PF syringes	
☐ Leukine® (Sargramostim)	☐ _____		_____# 250 mcg vials (powder for injection) _____# 500 mcg/mL vials	
☐ Other _____				
☐ Other _____				
☐ Other _____				

5. DELIVERY INSTRUCTIONS

☐ Physicians Office ☐ Patient's Home	☐ Other	Date Medication Needed
	Address	
	City/State/Zip	

6. PHYSICIAN CONTACT INFORMATION & AUTHORIZATION

Physician Name	Office Contact	Institution
Phone	Fax	Specialty
Address	City/State/Zip	
License #	DEA #	

Physician's Signature _____ **Date** _____
(required to process prescription – stamped signatures are not permissible)

Please fax to AllyScripts Specialty Pharmacy at 844-309-7173.
Faxed prescription forms will only be accepted from prescribing practitioners.