Anemia:
Colony Stimulating Factors
Enrollment Form

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

1. PATIENT

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

2. INSURANCE INFORMATION

Primary Insurance	Rx Ins. BIN_________ PCN________	Policyholder
Group #	Member ID #	Phone #
Secondary Insurance	Policy #	Phone #

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

☐ 285.21 Anemia in ESRD	☐ 285.22 Anemia in neoplastic disease	☐ 285.29 Anemia of other chronic disease

☐ 284.0 Constitutional aplastic anemia	☐ 284.8 Specified aplastic anemia	☐ 284.9 Aplastic anemia unspecified	☐ 285.0 Sideroblastic anemia	☐ 285.8 Anemia unspecified	☐ Other ICD-9 ___________

4. PRESCRIPTION INFORMATION

Medication	Dosage		Quantity	Refills
☐ Aranesp® Prefilled Syringe SingleJect (Darbepoetin alfa) ☐ Aranesp® Prefilled Syringe SureClick Autoinjector (Darbepoetin alfa) ☐ Aranesp® SD vial	**Chronic Kidney Disease** ☐ 0.45 mcg/kg SQ q week ☐ __________________ (Please fill in weight section if based on mg/kg)	**Oncology** ☐ 2.25 mcg/kg SQ q week ☐ 200 mcg SQ q 2 weeks ☐ 500 mcg SQ q 3 weeks ☐ _____________ **Other** ☐ __________________________	_______# Vials ________# syringes	
☐ Epogen® (Epoetin alfa)	**Chronic Kidney Disease** ☐ 50 units/kg SQ 3 times / week ☐ 75 units/kg SQ 3 times / week ☐ 100 units/kg SQ 3 times / week ☐ __________________________	**Other** ☐ __________________________ (Please fill in weight section if based on mg/kg)	____# Vials	
☐ Procrit® (Epoetin alfa)	**Oncology** ☐ 150 units/kg SQ 3 times / week ☐ 40,000 units SQ q week ☐ 60,000 units SQ q week ☐ __________________________	**Other** ☐ __________________________ (Please fill in weight section if based on mg/kg)	____# Vials	

DELIVERY INSTRUCTIONS

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

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)

AllyScripts 10/18

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