HEMATOLOGY REFERRAL FORM

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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): ______________________

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

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

Prescription Information

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		28-day supply	
☐ 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		28-day supply	
☐ 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			

Prescription information continued on next page

Prescription Information - Continued

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		28-day supply	
☐ Promacta (eltrombopag)	☐ 12.5mg Tablet ☐ 25mg Tablet ☐ 50mg Tablet ☐ 75mg Tablet	☐ Take 1 tablet by mouth once daily. ☐ Other:	30-day supply	
☐ 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: ______________________________

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