BLUEGRASS PHARMACY | HEMATOPOIETICS ENROLLMENT FORM

BLUEGRASS Pharmacy
A Member of the Wellpartner Family

FAX FORM TO: 1.866.233.8317 | **PHONE:** 1.855.492.0817 | **EMAIL:** contact@bluegrass-rx.com

Complete the following or include demographic sheet.

1. PATIENT INFORMATION

Name:
Address:
City, State, ZIP:
Primary Phone: - - DOB: / /
Alternate Phone: - - Gender:
Email:
Primary Language: Last Four of SSN:

2. PRESCRIBER INFORMATION

Name:
DEA #: NPI #: State Lic. #:
Group or Hospital:
Address:
City, State, Zip:
Phone: - - Fax: - -
Contact Person: Phone: - -

3. INSURANCE INFORMATION

*Fax copy of **prescription** and **insurance cards** with this form, if available (front and back)*

Primary Insurance Company Name:
Primary Cardholder Name:
Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent
Phone: - - Member ID: Group #:

Secondary Insurance Company Name:
Secondary Cardholder Name:
Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent
Phone: - - Member ID: Group #:

4. DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: / / Ship to: ◯ Patient ◯ Office ◯ Other:

Date of Diagnosis: / /
◯ D63.8 Anemia in other chronic diseases
◯ Other diagnosis (please include ICD-10 code):

Allergies:

Other Medications:
◯ Ribavirin (dose/strength: _____)
◯ Other(s):

Is injection training necessary? ◯ Yes ◯ No
If no, reason: ◯ Patient independent
◯ MD office trained patient or referred to other trainer

Lab Data (if applicable):
Last clinic visit: / / HGB: _____ HCT: _____ GFR: _____ Ferritin: _____
Platelets: _____ Creatinine clearance: _____ ml/min Serum creatinine: _____ mg/dl

Is patient's blood pressure under control?	◯ Yes ◯ No
Is patient being monitored for thrombotic/cardiac events?	◯ Yes ◯ No
Has anemia occurred due to hemolysis, nutritional deficiencies, or GI bleeds?	◯ Yes ◯ No
If patient is currently taking hematopoetics, provide evaluation of response to therapy:	
HGB rise ≥ _____ g/dL and/or HCT ≥ 3%	◯ Yes ◯ No
Dose or administration frequency is adjusted until Hgb level is ≤ 12 g/dL	◯ Yes ◯ No
Hgb increased more than 1 g/dL in a two-week period or Hgb level is approaching 12 g/dL	◯ Yes ◯ No
Dose to be reduced to avoid rapid rise in Hgb level	◯ Yes ◯ No

5. PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Qty	Refills
◯ Aranesp™	◯ 25 mcg ◯ 100 mcg ◯ 300 mcg ◯ 40 mcg ◯ 150 mcg ◯ 500 mcg ◯ 60 mcg ◯ 200 mcg ◯ Autoinjector ◯ PFS ◯ Vial	◯ Inject the entire contents of autoinjector/syringe SQ once every other week ◯ Inject the entire contents of autoinjector/syringe SQ once a week ◯ Other:		
◯ Epogen™	◯ 2,000 u/ml (SDV) ◯ 10,000 u/ml (SDV) ◯ 3,000 u/ml (SDV) ◯ 10,000 u/ml 2 ml vial (MDV) ◯ 4,000 u/ml (SDV) ◯ 20,000 u/ml 1 ml vial (MDV)	◯ Single-dose vial (SDV): Inject entire contents of 1 vial SQ: ◯ Once a week ◯ 3 times a week ◯ Other: ◯ Multi-dose vial (MDV): Inject _____ ml (_____ units) SQ: ◯ Once a week ◯ 3 times a week ◯ Other:		
◯ Leukine™	◯ 250 mcg vial (lyophilized) ◯ 500 mcg vial (liquid)	◯ Administer _____ mcg once a day for _____ days. (Circle IV or SC) ◯ Other:		
◯ Neulasta™	6 mg prefilled syringes (PFS)	◯ Inject 6 mg SQ day after chemotherapy, every _____ days. ◯ Other:		
◯ Neumega™	5 mg vial kit	◯ Mix and administer 50 mcg/kg once a day for _____ days. ◯ Other:		
◯ Neupogen™	◯ 300 mcg ◯ 480 mcg ◯ PFS ◯ Vial	◯ Administer _____ mcg once a day for _____ days. (Circle IV or SC) ◯ Other:		
◯ Procrit™	◯ 2,000 u/ml (SDV) ◯ 10,000 u/ml (SDV) ◯ 3,000 u/ml (SDV) ◯ 10,000 u/ml 2 ml vial (MDV) ◯ 4,000 u/ml (SDV) ◯ 20,000 u/ml 1 ml vial (MDV)	◯ Single-dose vial (SDV): Inject entire contents of 1 vial SQ: ◯ Once a week ◯ 3 times a week ◯ Other: ◯ Multi-dose vial (MDV): Inject _____ ml (_____ units) SQ: ◯ Once a week ◯ 3 times a week ◯ Other:		
◯ Other				

Ancillary supplies and kits will be provided as needed for administration.

6. PRESCRIBER SIGNATURE

X / /
DISPENSE AS WRITTEN DATE

X / /
PRODUCT SUBSTITUTION PERMITTED DATE