

PATIENT INFORMATION

Last Name	First Name	MI	ID Number
Home Address	City	State	Zip
Shipping Address (if different from home address)	<input type="checkbox"/> Ship to MD	Home Phone Number ()	Work Phone Number ()

INSURANCE INFORMATION (fill out entirely or fax a copy of patient's Insurance card, both sides)

Primary Insurance	Secondary Insurance
Insured	Insured
Policy Number	Policy Number
Group Number	Group Number

PRIMARY DIAGNOSIS

<input type="checkbox"/> anemia associated with chronic kidney disease	<input type="checkbox"/> secondary prophylaxis of febrile neutropenia
<input type="checkbox"/> anemia associated with cancer chemotherapy	<input type="checkbox"/> acute lymphoblastic leukemia
<input type="checkbox"/> anemia in patients with HIV infection receiving zidovudine therapy	<input type="checkbox"/> acute myeloid leukemia
<input type="checkbox"/> reduction of allogeneic blood transfusion	<input type="checkbox"/> myelodysplastic syndromes
<input type="checkbox"/> myelodysplastic syndrome	<input type="checkbox"/> lymphoma treated with chemotherapy
<input type="checkbox"/> anemia due to ribavirin use in patients with HCV	<input type="checkbox"/> radiation injury
<input type="checkbox"/> HIV and / or AIDs associated neutropenia	<input type="checkbox"/> myeloid engraftment following hematopoietic stem cell transplantation
<input type="checkbox"/> acute myelogenous leukemia	<input type="checkbox"/> severe chronic neutropenia and cyclic neutropenia
<input type="checkbox"/> primary prophylaxis of febrile neutropenia in patients receiving myelosuppressive chemotherapy	
<input type="checkbox"/> primary prophylaxis of febrile neutropenia in patients receiving NON-myelosuppressive chemotherapy	
<input type="checkbox"/> Other specify _____	

MEDICAL INFORMATION

Start Date _____ End Date _____ Next Chemotherapy Cycle _____
 Height _____ cm in Weight _____ kg lbs Date of Last measurement _____
 Hemoglobin _____ Hematocrit _____ WBC _____ ANC _____
 Endogenous erythropoietin _____ Ferritin _____ Platelet count _____
 Transferrin saturation (serum Fe/Fe binding capacity) _____ See Attached
 Allergies _____ NKDA
 HIV HBV HCV Cardiac Disease Diabetes Other _____ See Attached
 Current Medications _____ See Attached

PRESCRIPTION INFORMATION

<input type="checkbox"/> Aranesp	<input type="checkbox"/> Autoinjector <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Vial <input type="checkbox"/> 27g 1/2" 1cc Syringe <input type="checkbox"/> Other: _____
	<input type="checkbox"/> 25 mcg <input type="checkbox"/> 40mcg <input type="checkbox"/> 60mcg <input type="checkbox"/> 100mcg <input type="checkbox"/> 150mcg <input type="checkbox"/> 200 mcg <input type="checkbox"/> 300mcg <input type="checkbox"/> 500mcg
	SIG: _____ Qty: _____ Refills: _____
<input type="checkbox"/> Epogen	<input type="checkbox"/> 27g 1/2" 1cc Syringe <input type="checkbox"/> Other: _____
	<input type="checkbox"/> 2,000 U/mL <input type="checkbox"/> 3,000 U/mL <input type="checkbox"/> 4,000U/mL <input type="checkbox"/> 10,000U/mL <input type="checkbox"/> 10,000U/mL 2mL MDV <input type="checkbox"/> 20,000U/mL MDV <input type="checkbox"/> 40,000U/mL
	SIG: _____ Qty: _____ Refills: _____
<input type="checkbox"/> Leukine	<input type="checkbox"/> 250mcg vial <input type="checkbox"/> 500mcg vial <input type="checkbox"/> 27g 1/2" 1cc Syringe <input type="checkbox"/> Other: _____
	SIG: _____ Qty: _____ Refills: _____
<input type="checkbox"/> Neulasta	<input type="checkbox"/> 6mg Prefilled Syringe <input type="checkbox"/> Other: _____
	SIG: _____ Qty: _____ Refills: _____
<input type="checkbox"/> Neumega	<input type="checkbox"/> 5mg vial <input type="checkbox"/> Other: _____
	SIG: _____ Qty: _____ Refills: _____
<input type="checkbox"/> Neupogen	<input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Vial <input type="checkbox"/> 27g 1/2" 1cc Syringe <input type="checkbox"/> Other: _____
	<input type="checkbox"/> 300 mcg <input type="checkbox"/> 480mcg
	SIG: _____ Qty: _____ Refills: _____
<input type="checkbox"/> Procrit	<input type="checkbox"/> 27g 1/2" 1cc Syringe <input type="checkbox"/> Other: _____
	<input type="checkbox"/> 2,000 U/mL <input type="checkbox"/> 3,000 U/mL <input type="checkbox"/> 4,000U/mL <input type="checkbox"/> 10,000U/mL <input type="checkbox"/> 10,000U/mL 2mL MDV <input type="checkbox"/> 20,000U/mL MDV <input type="checkbox"/> 40,000U/mL
	SIG: _____ Qty: _____ Refills: _____

PRESCRIBER INFORMATION

Prescriber	Specialty	Office Contact	Phone Number
Address	City	State	Zip
Today's Date	Date Needed	I certify that the above therapy is medically necessary and all the above information is accurate to the best of my knowledge. Physician's Signature _____	NPI _____ DEA _____

Refrigerated prescriptions are shipped Mon. - Thurs. via standard overnight service. Saturday delivery requires approval from an Ascend pharmacist.
For refills, please call-in or fax 7 days in advance of next appointment.

CONFIDENTIALITY STATEMENT: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone.

