MedicoRx Specialty & HOME INFUSION PHARMACY

Thrombocytopenia

REFERRAL FORM

Phone: 818-390-9696 Toll-free: 855-265-7850 ● Fax: 818-804-3492 Toll-free fax: 855-450-6717 ● info@MedicoRX.com

Patient information		Prescriber information	
Name:	**DOB:**	**Prescriber's Name:**	
Address: **City, State, Zip**		**NPI#**	
		DEA#	**License#**
Phone #	**Alt#**	**Address** **City, State, Zip**	
SSN:			
Height:	**Wt:**	**Phone #**	**Fax #**
Allergies:			
Emergency Contact/ Phone #		**Contact Person:**	

Clinical Consideration

Diagnosis (ICD 10) : □ D69.42 Congenital and hereditary thrombocytopenia purpura

□ D69.49 Other primary thrombocytopenia

□ D69.59 Other secondary thrombocytopenia

□ D69.6 Thrombocytopenia, unspecified

□ D75.82 Heparin induced thrombocytopenia (HIT)

Other (please specify)____

Current Platelet Count : ________ X 10^9 L

Medication	Dose/Strength	Directions for Use	Quantity	Refills
□ **Nplate®** (Romiplostim)	□ Administer initial dose 1 mck/kg SC, based on ABW, then adjust dose weekly per new order. □ Administer SC dose of _____ X _____ weeks □ Other : __________			
□ **Promacta® (Eltrombopag)**	□ 12.5 mg tablet □ 25 mg tablet □ 50 mg tablet □ 75 mg tablet □ 100 mg tablet	□ Once Daily □ Once Daily □ Once Daily □ Once Daily □ Once Daily		

By signing this form I authorize MedicoRX and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

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Prescriber's signature (no stamps) if brand required check this ☐ DAW___ **Date**