MedicoRx Specialty & HOME INFUSION PHARMACY

Hematopoietic
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 Considerations
Diagnosis (ICD 10) :____ □ Other (please specify)_________________________________

Drug Name	Strength/Directions for use		Refills
□ **Aranesp**	□ 25mcg □40mcg □50mcg □ 100mcg □150mcg □200mcg □ 300mcg □ 500mcg	□ Inject entire contents of syringe SC once every OTHER week □ Inject entire contents of syringe SC once EVERY week	
□ **Epogen**	□ 2,000 u/ml SDV □ 3,000 u/ml SDV □ 4,000 u/ml SDV □ 10,000 u/ml SDV □ 10,000 u/ml 2ml MDV □ 20,000 u/ml 1ml MDV	Single Dose Vial (SDV): Inject the entire contents of vial subcutaneously □ Once weekly □ 3 times a week □ Other: ____________	
□ **Leukine**	□ 250 mcg vial (lyophilized) □ 500 mcg/ml vial (liquid)	□ 250 mcg/m2/day______ SC once a day for ______days □ Other:____	
□ **Neulasta**	□ 6mg prefilled syringe	□ Administer 6mg (1 syringe) SC once per chemotherapy cycle □ Other: ____	
□ **Neumega**	□ 5mg vial kit	□ Mix & administer 50ug/kg/day once a day for ____days	
□ **Neupogen**	□ 300mcg □ 480mcg	□ Administer 5mcg/kg/day ____ SC once a day for ____ days	
□ **Procrit**	□ 2,000 u/ml SDV □ 3,000 u/ml SDV □ 4,000 u/ml SDV □ 10,000 u/ml SDV □ 10,000 u/ml 2ml MDV □ 20,000 u/ml 1ml MDV	Single Dose Vial (SDV): Inject the entire contents of vial subcutaneously □ Once weekly □ 3 times a week □ Other: ____________	
Dispense Quantity_______________ Refill ________times			

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**