meijer specialty pharmacy

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Oncology Support Medications (P-Z)

Prescriber Information

Prescriber Name:	○ MD ○ DO ○ NP ○ PA	NPI:	
Office Contact:	Practice Name / Collaborating MD:		
Address:	City:	State:	Zip:
Phone:	Fax:		

Patient Information • PLEASE SEND COPY OF INSURANCE CARD

Patients Name:	Last 4 Digits of SS#:	DOB: / /	Sex: ○ M ○ F	Weight:	Height:	Diabetic? ○ Y ○ N
Office Contact:	Practice Name / Collaborating MD:					
Address:	City:	State:	Zip:			
Home Phone:	Work/Cell:	HIPPA Contact:	Emergency #:			
Interpreter Needed? ○ Y ○ N	Allergies: ○ Y ○ N **If Yes, list allergies:**					

Insurance Information

Primary Insurance:	Policy ID:	Group #:	BIN:	PCN:
Policyholder Name:	Policyholder DOB: / /			

Clinical Information • PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES AND LAB VALUES

ICD-10 Code:	Weight: ○ lb / ○ kg	Height: ○ in / ○ cm	BSA m2	Diagnosis Date: / /
Current SCr or current GFR ml/min	Confirmed Mutations:			
Prior Therapy:	Reason for Discontinuation of Therapy:	Approximate Start Date	Approximate End Date	

Prescription Information

Medication	Strength	Sig	Quantity	Refills
○ **PROCRIT®** (erythropoietin)				
○ **PROMACTA®** (eltrombopag)	○ 12.5mg ○ 25mg ○ 50mg ○ 75mg			
○ **RETACRIT™** (epoetin-epbx)				
○ **SANDOSTATIN® LAR** (octreotide)				
○ **SANDOSTATIN®** (octreotide)				
○ **SOMATULINE®** (lanoreotide)				
○ **UDENYCA™** (pegfilgrastim-cbqv)				
○ **XGEVA®** (denosumab)				
○ **ZARXIO®** (filgrastim-sndz)				
○ **ZIEXTENZO™** (pegfilgrastim-bmez)				
○ **OTHER**				

By signing this form and utilizing our services, you are authorizing Meijer and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature	Date	Prescriber Signature	Date

Substitution Permitted

Dispense as Written

If brand is required, please write "DAW" in the box to the right.