NOBLE HEALTH SERVICES

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# Hematopoietics

Delivery Need By: _____ Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Other _____

## PATIENT INFORMATION

Patient Name: _____ ☐ Male
Address: _____ ☐ Female
City: _____ State: _____ Zip: _____
Phone Number: _____
Email Address: _____
Last Four of Social: _____ DOB: _____

## PRESCRIBER INFORMATION

Prescriber's Name: _____
Office Contact Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____ Fax: _____
DEA/NPA #: _____

**INSURANCE – PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK**

## CLINICAL INFORMATION

Diagnosis: _____

ICD-10 Code: _____

Height: _____ ft _____ inches Weight: _____ lbs

Last PPD Test: ☐ Positive ☐ Negative Date: _____

Allergies: _____

Has the patient been treated previously for this condition?

☐ Yes ☐ No

Medications Failed: _____
Medications On: _____
Other Notes: _____

## PRESCRIPTION INFORMATION

| Medication: | Dosage/Strength: | | Directions: | | Quantity: | Refills: |
|---|---|---|---|---|---|---|
| Aranesp | ☐ 25 mcg<br>☐ 40 mcg<br>☐ 60 mcg<br>☐ 100 mcg | ☐ 150 mcg<br>☐ 200 mcg<br>☐ 300 mcg<br>☐ 500 mcg | ☐ Inject the entire contents of autoinjector/syringe SC once every other week.<br>☐ Inject the entire contents of autoinjector/syringe SC once a week<br>☐ Other | | ☐ _____ Autoinjector<br>☐ _____ Pre-filled syringes<br>☐ _____ Vials<br>☐ Other | |
| | ☐ Auto Injector ☐ Prefilled Syringe ☐ Vial | | | | | |
| Epogen | Single Dose Vial:<br>☐ 2,000u/ml<br>☐ 3,000u/ml<br>☐ 4,000u/ml<br>☐ 10,000u/ml | Multi-Dose Vial:<br>☐ 20,000u/ml 1ml vial<br>☐ 10,000u/ml 2ml vial | Single Dose Vial:<br>☐ Inject the entire contents of 1 vial SC once a week<br>☐ Inject the entire contents of 1 vial SC three times a week | Multi-Dose Vial:<br>☐ Inject _____ ml (____ units) SC once a week<br>☐ Inject _____ ml (_____ units) SC three times a week | ☐ _____ Single-Dose Vials<br>☐ _____ Multi-Dose Vials | |
| | | | ☐ Other | | | |
| Granix | Single-Dose Vial:<br>☐ 300 mcg/1mL<br>☐ 480 mcg/1.6mL | Pre-Filled Syringe:<br>☐ 300 mcg/0.5ml<br>☐ 480 mcg/0.8ml | ☐ | | ☐ _____ Single-Dose Vials<br>☐ _____ Pre-Filled Syringes | |
| Leukine | ☐ 250 mcg vial (lyophilized)<br>☐ 500 mcg/ml vial (liquid) | | ☐ Administer _____ mcg IV once a day for _____ days.<br>☐ Administer _____ mcg SC once a day for _____ days. | | ☐ _____ Vials | |
| Neulasta | ☐ 6mg/0.6 mL prefilled Syringe | | ☐ Inject _____ mg SC every _____ days as directed<br>☐ Other | | ☐ _____ prefilled Syringes | |
| ☐ Patient is interested in patient support programs | | | ☐ Ancillary supplies provided for administration | | | |

Physician Signature: _____ Date: _____



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# Hematopoietics

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## PATIENT INFORMATION

Patient Name: _____ ☐ Male
Address: _____ ☐ Female
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Email Address: _____
Last Four of Social: _____ DOB: _____

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Office Contact Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____ Fax: _____
DEA/NPA #: _____

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Last PPD Test: ☐ Positive ☐ Negative Date: _____

Allergies: _____

Has the patient been treated previously for this condition?

☐ Yes ☐ No

Medications Failed: _____
Medications On: _____
Other Notes: _____

## PRESCRIPTION INFORMATION

| Medication: | Dosage/Strength: | | Directions: | | Quantity: | Refills: |
|---|---|---|---|---|---|---|
| Neupogen | Vial:<br>☐ 300 mcg/ 1 ml vial<br>☐ 480 mcg/0.8 ml vial | Pre-Filled Syringe:<br>☐ 300 mcg/0.5 ml Syringe<br>☐ 480/0.8ml prefilled syringe | ☐ Administer ____ mcg IV once a day for _____ days<br>☐ Administer ____ mcg SC once a day for _____ days | | ☐ _____ Vials<br>☐ _____ prefilled syringe | |
| Procrit | Single-Dose Vial:<br>☐ 2,000u/ml<br>☐ 3,000u/ml<br>☐ 4,000u/ml<br>☐ 10,000u/ml | Multi-Dose Vial:<br>☐ 20,000u/ml 1 vial<br>☐ 10,000u/ml 2 ml vial | Single Dose Vial:<br>☐ Inject the entire contents of 1 vial SC once a week<br>☐ Inject the entire contents of 1 vial SC three times a week | Multi-Dose Vial:<br>☐ Inject _____ ml (____ units) SC once a week<br>☐ Inject _____ ml (_____ units) SC three times a week | ☐ _____ Multi-Dose Vials<br>☐ _____ Single-Dose Vials | |
| Zarxio | ☐ 300 mcg prefilled syringe<br>☐ 480 mcg prefilled syringe | | ☐ Administer _____ mcg IV once a day for _____ days.<br>☐ Administer _____ mcg SC once a day for _____ days. | | ☐ _____ Prefilled Syringes | |
| Other | | | | | | |

☐ Patient is interested in patient support programs

☐ Ancillary supplies provided for administration

Physician Signature: _____ Date: _____



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