Procrit® Enrollment Form

Healthy CORNER PHARMACY

Fax Referral To: 1-718-261-6689 **Phone:** 1-855-261-6699

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ Address: _____ City, State, ZIP: _____

Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)

Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.

Primary Phone: _____ Alternate Phone: _____ DOB: _____ Gender: ☐ Male ☐ Female

Email: _____ Last Four of SSN: _____ Primary Language: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____

NPI #: _____ DEA #: _____ Group or Hospital: _____

Address: _____ City, State, ZIP: _____

Phone: _____ Fax _____ Contact Person: _____ Contact's Phone: _____

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____ Ship to: ☐ Patient ☐ Office ☐ Other: _____

Diagnosis (ICD-10):

☐ D63.0 Anemia in neoplastic disease
☐ D63.1 Anemia in chronic kidney disease
☐ D63.8 Anemia in other chronic diseases classified elsewhere
☐ D64.81 Anemia due to antineoplastic chemotherapy
☐ D64.9 Anemia unspecified
☐ Other Code: _____ Description: _____

For additional ICD-10 information, please visit www.icd10-data.com

Patient Clinical Information:

Allergies: _____ Height: _____in/cm Weight: _____lb/kg

5 PRESCRIPTION INFORMATION

MEDICATION	DOSE	DIRECTIONS	QUANTITY/REFILLS
☐ Procrit *epoetin alfa*	☐ 2,000 units/ml (single-dose vial) ☐ 3,000 units/ml (single-dose vial) ☐ 4,000 units/ml (single-dose vial) ☐ 10,000 units/ml (single-dose vial) ☐ 10,000 units/ml – 2 ml vial (multi-dose vial) ☐ 20,000 units/ml – 1 ml vial (multi-dose vial) ☐ 40,000 units/ml (single-dose vial)	☐ Single-dose Vial: Inject the entire contents of 1 vial SC. ☐ Once a Week ☐ 3 Times a Week ☐ Other:_____ ☐ Multi-dose Vial: Inject_____ ml (_____units) SC. ☐ Once a Week ☐ 3 Times a Week ☐ Other:_____ ☐ Include 25G 5/8" syringes, alcohol pads, and sharps container – *free of charge*	Quantity: ___ Refills: _____

Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

6 PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED (Date)

X_____

DISPENSE AS WRITTEN (Date)

X_____

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing below, I hereby authorize Healthy Corner Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.