Zarina Pharmacy
SPECIALTY & INFUSION

Blood Modifying Agents A-M

Fax: 832-886-4298 Phone: 832-886-4296 zarinapharmacy.com

Need By Date: _____ Ship To: ☐Patient ☐Office ☐Other _____ Fax Copy: ☐Rx Card Front/Back ☐Clinical Notes ☐Medical Card Front/Back

Patient Information

Patient Name		
Address		
City State Zip		
Main Phone	Alternate Phone	
Social Security #		
Date of Birth	☐Female ☐Male	

Prescriber Information

Prescriber Name		
Address		
City State Zip		
Phone	Fax	
Contact Person		
DEA #	NPI #	License #

Clinical Information

Primary Diagnosis	ICD-10	Secondary Diagnosis	ICD-10
Primary Diagnosis	ICD-10	Secondary Diagnosis	ICD-10
Drug Allergies		Status: ☐New ☐Restart ☐Continuing	

Please Attach Supporting Labs and List of OTHER Medications

Med	Dose/Strength	Directions	Qty	Refills
☐**Aranesp®**	**SDV:** ☐25mcg/1mL ☐40mcg/1mL ☐60mcg/1mL ☐100mcg/1mL ☐200mcg/1mL ☐300mcg/1mL		_____	_____
	PFS: ☐10mcg/0.4mL ☐25mcg/0.42mL ☐40mcg/0.4mL ☐60mcg/0.3mL ☐100mcg/0.5mL ☐150mcg/0.3mL ☐200mcg/0.4mL ☐300mcg/0.6mL ☐500mcg/1mL		_____	_____
☐**Doptelet®**	☐ **20mg Tablet** **Procedure Date** ***(for Chronic Liver Disease-associated thrombocytopenia)*****:** _____		_____	_____
☐**Elitek®**	**PWVL:**☐**1.5mg** ☐**7.5mg**		_____	_____
☐**Epogen®**	**SDV:** ☐**2,000 Units/1mL** ☐**3,000 Units/1mL** ☐**4,000 Units/1mL** ☐**10,000 Units/1mL**		_____	_____
	MDV: ☐**20,000 Units/2mL** ☐ **20,000 Units/1mL**		_____	_____
☐**Exjade®**	**Tablet for Oral Suspension:** ☐**125mg** ☐**250mg** ☐**500mg**		_____	_____
☐**Fulphila®**	**PFS: 6mg/0.6mL**		_____	_____
☐**Granix®**	**PFS:** ☐**300mcg/0.5mL** ☐**480mcg/0.8mL**		_____	_____
	SDV: ☐**300mcg/1mL** ☐**480mcg/1.6mL**		_____	_____
☐**Jadenu®**	**Tablet:** ☐**90mg** ☐**180mg** ☐**360mg**		_____	_____
	Granules: ☐**90mg** ☐**180mg** ☐**360mg**		_____	_____
☐**Leukine®**	☐**250mcg PWVL** ☐**500mcg/1mL SDV**		_____	_____
☐**Mozobil**	**SDV: 24mg/1.2mL**		_____	_____
☐**Other**				

By signing this form, you are authorizing BioPlus Specialty Pharmacy and its employees to serve as your designated agent in submitting clinical and other required information to third party payors with respect to this prescription and any refills or continuation of the same medication and dose for this patient. IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged property or exempt from disclosure under applicable law. If you are not the named addressee you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

_____ _____ _____ _____

Prescriber's Signature (no stamps) **Substitution Permitted** **Date** **Prescriber's Signature** (no stamps) **Dispense As Written** **Date**

Zarina Pharmacy
SPECIALTY & INFUSION

Blood Modifying Agents N-Z

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Patient Information

Patient Name	
Address	
City State Zip	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	☐Male ☐Female

Prescriber Information

Prescriber Name		
Address		
City State Zip		
Phone	Fax	
Contact Person		
DEA #	NPI #	License #

Clinical Information

Primary Diagnosis	ICD-10	Secondary Diagnosis	ICD-10
Primary Diagnosis	ICD-10	Secondary Diagnosis	ICD-10
Drug Allergies		Status: ☐New ☐Restart ☐Continuing	

Please Attach Supporting Labs and List of OTHER Medications

Med	Dose/Strength	Directions	Qty	Refills
☐Neulasta®	☐6mg/0.6mL PFS ☐Onpro Kit		_____	_____
☐Neupogen®	SDV: ☐300mcg/1mL ☐480mcg/1.6mL		_____	_____
	PFS: ☐300mcg/0.5mL ☐480mcg/0.8mL		_____	_____
☐Nivestym®	SDV: ☐300mcg/1mL ☐480mcg/1.6mL		_____	_____
	PFS: ☐300mcg/0.5mL ☐480mcg/0.8mL		_____	_____
☐Nplate®	PWVL: ☐125mcg ☐250mcg ☐500mcg		_____	_____
☐Nyvepria™	PFS: 6mg/0.6mL		_____	_____
☐Procrit®®	SDV: ☐2,000 Units/1mL ☐3,000 Units/1mL ☐4,000 Units/1mL ☐10,000 Units/1mL ☐40,000 Units/1mL		_____	_____
	MDV: ☐20,000 Units/2mL ☐20,000 Units/1mL		_____	_____
☐Promacta®	Tablet: ☐12.5mg ☐25mg ☐50mg ☐75mg		_____	_____
	Powder for Oral Suspension: ☐12.5mg ☐25mg		_____	_____
☐Retacrit®	SDV: ☐2,000 Units/1mL ☐3,000 Units/1mL ☐4,000 Units/1mL ☐10,000 Units/1mL ☐40,000 Units/1mL		_____	_____
☐Udenyca®	PFS: 6mg/0.6mL		_____	_____
☐Zarxio®	PFS: ☐300mcg/0.5mL ☐480mcg/0.8mL		_____	_____
☐Ziextenzo®	PFS: 6mg/0.6mL		_____	_____
☐Other				

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Prescriber's Signature (no stamps) **Substitution Permitted** **Date** **Prescriber's Signature** (no stamps) **Dispense As Written** **Date**