



ANEMIA / NEUTROPENIA

Phone Number	r : 714 -3	364-400	8	Fax Nu	mber: 714-364-4666	Today's Date:	
Patient Name: Address: City: Cell: Date of Birth: Weight:(I Allergies:	bs/kg) H	Stat Wo eight:	re: rk: S B	Zip: ex: / F sSA:(State Lic. #: Name of Practice Address: City: m ²) Phone:	DEA: ::State:Zip:_ Fax:	
Deliver Rx To:		ent's Hom		scriber's Offi			
Medical History		y Dx: (ICD-9 dary Dx: (I de:		(Description (Description (Description)	Estimated Duration of Therapy: Date Prescriptions Needed in Office:	
Select from the	followi	ng comm	nonly used	d medicatio	ons: (CMS Guideline Ap	plies – MUST attach recent HgB/	HcT lab values
Drug Name	2	JCODE	Dose	Quantity	Directions (inc	lude route and frequency)	Refills
🗆 Neupogen (filgra	astim)	J1440	300mcg				
🗆 Neupogen (filgra							
	astim)	J1441	480mcg				
 Neupogen (ling) Neulasta 	astim)	J1441 J2505	480mcg				
	astim)	-	480mcg				
Neulasta	astim)	J2505	480mcg				
 Neulasta Epogen (ESRD) 	astim)	J2505 J0886	480mcg				
Neulasta Epogen (ESRD) Procrit	astim)	J2505 J0886 J0885	480mcg				
 Neulasta Epogen (ESRD) Procrit Aranesp 	astim)	J2505 J0886 J0885 J0881	480mcg				

Unless indicated, Generic Substitution Allowed

Please attach a copy of the patient's insurance card.

Physician's Signature

(Physician signature required to validate prescriptions)





CHEMOTHERAPEUTIC AGENTS

Phone Number	r : 714 -:	364-400	8	Fax Nu	mber	: 714-364-4666	Today's Date:	
Patient Name:						Physician Name:		
Address:						State Lic. #:	DEA:	
City:		Stat	e:	Zip:		Name of Practice		
Cell:	Work:					Address:		
Date of Birth:	Sex: K / F						State:Zip:	
Weight:(I	bs/kg) H	leight:	B	SA:	(m²)	Phone:	Fax:	
Allergies:						Office Contact:		
Deliver Rx To:						Other: (please specify		
Medical	Prima	ry Dx: (ICD-9)	(Description	n)		Current Stage of Cancer:	
History	Secon	dary Dx: (#	CD-9)	(Description	n)			
-	CPT Co			(Description	-		Estimated Duration of Therapy:	
This is For		-				ion of Treatment	Date Prescriptions	
Intent to Treat	🗆 Adju	ivant	Curative	🗆 Pal	liative		Needed in Office:	
Select from the	followi	. –	nonly used	d medicatio	ons:			
Drug Name	9	JCODE	Dose	Quantity		Directions (inc	lude route and frequency)	Refills
				Pre-n	neds an	d Anti-Emetics		
Diphenhydramii	ne	J1200						
Dexamethasone	2	J1100						
Ondansetron		J2405						
Granisetron		J1626						
🗆 Other								
Par	enteral	Chemoth	erapy (Plea	ase list the cl	hemoth	nerapy regimen be	low and attach any applicable labs)	
	Growt	h Factor N	Nedication	s (CMS Guid	leline A	pplies – MUST atta	ach recent HgB/HcT lab values)	
Deupogen (Filgr	astim)	J1440	300mcg					
🗆 Neupogen (Filgr	astim)	J1441	480mcg					
Procrit		J0885						
Aranesp		J0881						
Unless indicated	d, Gene	ric Substit	ution Allo	wed	1			

Please attach a copy of the patient's insurance card.

Physician's Signature

(Physician signature required to validate prescriptions)





CROHN'S DISEASE

Phone Number	r: 714-3	64-400	8	Fax Nu	mber: 714-364-4666	5 Today's Date:	
Patient Name: Address: City: Cell: Date of Birth: Weight:(I Allergies:	bs/kg) He	State Wor eight:	e: k:s f	Zip: Sex: <u>M / F</u> 3SA:	State Lic. #: Name of Practice Address: City: (m²)	DEA: e:State:Zip:_ Fax:	
Deliver Rx To:		nt's Hom		scriber's Off			
Medical History		y Dx: (ICD-9) ary Dx: (IC de:		(Descriptio (Descriptio (Descriptio	n)	Estimated Duration of Therapy: Date Prescriptions Needed in Office:	
Select from the	followin	ig comm	only use	d medicatio	ons:		
Drug Name	e	JCODE	Dose	Quantity	Directions (inc	clude route and frequency)	Refills
Remicade		J1745					
🗆 Humira		J0135					
🗆 Cimzia		J0718					
Tysabri		J2323					
🗆 Other							
Unless indicated	d, Generi	ic Substit	ution Allo	wed			L

Please attach a copy of the patient's insurance card.

Physician's Signature

(Physician signature required to validate prescriptions)



HEPATITIS C



Phone Number	r: 714-364-4008	Fax Number:	714-364-4666	Today's Date:	: <u></u>
Patient Name:			Physician Name:		
				_DEA:	
	State:				
	Work:				
				State:	
Weight:(I	bs/kg) Height:	_BSA:(m²)	Phone:	Fax:	
Allergies:			Office Contact:		
Deliver Rx To:	Patient's Home Pr	rescriber's Office	Other: (please specify)		
	Diagnosis: 070.54: Hep	oC (Chronic) 🗆 Other I	CD-9	Cirrhosis: Compensated Cirrhosis:	Decompensated
Medical	Genotype: 1 1 1 1 1 1 1 1 1 1 1 1 1	o □ 2 □ 2a □ 2b □ 3			
History	🗆 Treatment Naïve 🗆 Pre			Estimated Duration of Therap	y (weeks):
nistory	Non-Responder			Date Prescriptions	
	*****PLEASE FAX ALL HE	PATITIS LABORATORY INFO	DRMATION*****	Needed in Office:	
Hepatitis C Com	bination Therapy (IFN +	· RBV +/- PI)			
	□ PFS □ Vial (W □ 180mcg SQ weekly	/ill dispense as PFS un □ 135mcg SQ weekly		, ., <u> </u>	Refills:
	🗆 Redipen 🛛 🗆 Vial			Qty: 28 day supply	Refills:
	Pediatric (3-17yrs):		• • • •	t e: BSA Dosing)	
	Adult: 1.5 mcg/kg/w				
Pounds	Kilogram	Strength		PEG-INTRON (mcg/ml)	
Less than 88 88 – 111	Less than 40 40 – 50	50mcg / 0.5ml		□ 50mcg (0.5 ml) SQ weekly □ 64 mcg (0.4 ml) SQ weekly	
112 – 133	40 - 50	80 mcg / 0.5ml		\square 80 mcg (0.5 ml) SQ weekly	
134 – 166	61 – 75	120 mcg / 0.5ml		□ 96 mcg (0.4 ml) SQ weekly	
167 – 187	76 – 85	-		□ 120 mcg (0.5ml) SQ weekly	
188 – 231 Greater than 231	86 – 105 Greater than 105	150 mcg / 0.5ml	5 mcg/kg/wkmc	□ 150 mcg (0.5ml) SQ weekly g SQ weekly (nearest available dose	2)
		•			
RIBAVIRIN Pounds	Ribavirin 200mg cap	os 🗆 RIBAPAK® (Riba		Qty: <u>28 day supply</u>	Refills:
Less than 145	Kilogram Less than 66			rug Dosing tab QAM; 400 mg tab QPM	
145 – 177	66 - 80			g tab QAM; 400 mg tab QPM	
178 – 231	81 - 105			g tab QAM; 600 mg tab QPM	
Greater than 231	Greater than 105		🗆 1400 mg: 800 mg	g tab QAM; 600 mg tab QPM	
		If RIBAPAK		RIBAPAK® tab QAM + ribavirin 200r RIBAPAK® tab QPM	ng QAM;
Other Ribavirin	dosing:		000 mg 1		
🗆 INCIVEK® (tela	previr) 375mg tab			oceprevir) 200 mg caps*	
	2 x 375mg) po TID (7 to 9 h	ours) with non-low	-	4 x 200mg) po TID (7 to 9 hou	rs)
fat meal	<u> </u>		• •	lead in of interferon-alfa and	
	Qty: <u>28 day supply</u>	Refills:			efills:
Others:					
	-1	ise attach a conv of			

Physician's Signature

(Physician signature required to validate prescriptions)





MULTIPLE SCLEROSIS

Phone Number	r: 714-3	64-400	3	Fax Nun	nber: 714-364-4666	Today's Date:	
Patient Name: Address: City: Cell: Date of Birth: Weight:(I Allergies:	bs/kg) He	State Wor eight:	e: k: 	Zip: Sex:/ F BSA:(n	State Lic. #: Name of Practice Address: City: 2)	:DEA: e:State:Zip: Fax:	
Deliver Rx To:		nt's Hom		escriber's Office			
Medical History	Primary Dx: (ICD-9)(Description)Secondary Dx: (ICD-9)(Description)CPT Code:(Description)					Estimated Duration of Therapy: Date Prescriptions Needed in Office:	
Select from the							Defille
Drug Name		JCODE	Dose	Quantity	Directions (inc	clude route and frequency)	Refills
Betaseron (IFN (
Copaxone	5 1.57						
□ Rebif							
🗆 Tysabri							
🗆 Other							
Unless indicated	d, Generi	c Substit	ution Allo	wed			

Please attach a copy of the patient's insurance card.

Physician's Signature

(Physician signature required to validate prescriptions)





OSTEOARTHRITIS

Phone Number	r: 714-364-400	8	Fax Num	ber: 714-364-4666	Today's Date:	
Patient Name: Address: City: Cell: Date of Birth: Weight:(I Allergies: Deliver Rx To:	StatWoi Woi bs/kg) Height:	e: rk: f	Zip: Sex:M / F 3SA:(m	State Lic. #: Name of Practice Address: City: 2`) Phone: Office Contact:	DEA: e:State:Zip: Fax:	
Medical History	Primary Dx: (ICD-9 Secondary Dx: (I CPT Code:)	(Description) (Description) (Description)		Estimated Duration of Therapy: Date Prescriptions Needed in Office:	
Select from the	following comm	nonly use	d medication	s:		
Drug Name	JCODE	Dose	Quantity	Directions (inc	lude route and frequency)	Refills
🗆 Hyalgan	J7321					
🗆 Synvisc	J7325					
Orthovisc	J7324					
🗆 Euflexxa	J7323					
🗆 Stelara	J3357					
Others						
Unless indicated	d, Generic Substit	ution Allo	wed			

Please attach a copy of the patient's insurance card.

Physician's Signature

(Physician signature required to validate prescriptions)



LaSale,

OSTEOPOROSIS

Phone Numbe	r: 714-364-40	08	Fax Numbe	er: 714-364-4666	Today's Date:		
Address: City: Cell:	StaWo	ate: ork:		State Lic. #: Name of Practice Address: City: Phone:	DEA: e:State:Zip: Fax:		
Deliver Rx To:				Other: (please specif			
Medical History	Primary Dx: (ICD Secondary Dx: CPT Code: Tried and failed	(ICD-9)	(Description) (Description) (Description) honates: D NO	Yes (specify:)	T-score: Location of T-score test: Estimated Duration of Therapy: Date Prescriptions Needed in Office:		
Select from the	following com	monly use	ed medications:				
Drug Name	e JCODE	Dose	Quantity	Directions (inc	lude route and frequency) Refills		
🗆 Boniva	J1740						
🗆 Forteo	J3110						
Reclast	J3488						
🗆 Prolia	J0897						
🗆 Xgeva							
🗆 Other							

Unless indicated, Generic Substitution Allowed

Please attach a copy of the patient's insurance card.

Physician's Signature

(Physician signature required to validate prescriptions)



PSORIASIS



Phone Numbe	r: 714-364-400)8	Fax Nu	mber: 714-364-4666	Today's Date:	
Patient Name: Address: City: Cell: Date of Birth: Weight:(I Allergies:	StaWo Wo bs/kg) Height:	te: ork:	Zip: Sex: <u>M / F</u> BSA:(State Lic. #: Name of Practice Address: City: m ²) Phone:	DEA: ::State:Zip Fax:	
Deliver Rx To:	Patient's Hor					
Medical History	Primary Dx: (ICD Secondary Dx: (CPT Code:		(Description, (Description, (Description,)	Estimated Duration of Therapy: Date Prescriptions Needed in Office:	
Select from the	following comr	nonly use	d medicatio	ns:		
Drug Name	e JCODE	Dose	Quantity	Directions (inc	lude route and frequency)	Refills
🗆 Enbrel	J1438					
Remicade	J1745					
🗆 Humira	J0135					
🗆 Simponi	J3590					
🗆 Amevive	J0215					
🗆 Stelara	J3357					
🗆 Other:						
			1 1			

Unless indicated, Generic Substitution Allowed

Please attach a copy of the patient's insurance card.

Physician's Signature

(Physician signature required to validate prescriptions)



🗆 Enbrel

□ Remicade

J1438

J1745

TREATMENT REQUEST FORM



RHEUMATOID ARTHRITIS

Phone Numbe	r: 714-364-400	8	Fax Nu	mber: 714-364-466	5 Today's Date:		
Patient Name:				Physician Name	:		
Address:				State Lic. #:	DEA:		
City:	Stat	e:	Zip:	Name of Practic	e:		
Cell:	Wo	rk:		Address:			
Date of Birth:		:	Sex: <u>M / F</u>		State:Zip:		
Weight:(bs/kg) Height:		BSA:	(m²) Phone:	Fax:		
Allergies:				Office Contact:			
Deliver Rx To: Medical	Primary Dx: (ICD-9		escriber's Offi		ify) Severity of RA: Mild Moderate Severe		
History	Secondary Dx: (#	CD-9)	(Description	n)	Tried and failed, or contraindicated to MTX		
nistory			(Description	n)	🗆 Yes 🗆 No		
				Yes (specify below)	Estimated Duration of Therapy:		
			ulfidine 🗆	Imuran 🗆 Neoral	Date Prescriptions		
	🗆 Other:				Needed in Office:		
Select from the	following comm	only use	d medicatio	ons:			
Drug Name	e JCODE	Dose	Quantity	Directions (in	clude route and frequency) Refills		
🗆 Humira	J0135						

Unless indicated, G	Unless indicated, Generic Substitution Allowed							
Others								
🗆 Kineret	J3490							
🗆 Actemra	J3262							
🗆 Rituxan	J9310							
🗆 Simponi	J3590							
🗆 Cimzia	J0718							

Please attach a copy of the patient's insurance card.

Physician's Signature

(Physician signature required to validate prescriptions)