TREATMENT REQUEST FORM

ANEMIA / NEUTROPENIA

Phone Number: 714-364-4008 **Fax Number: 714-364-4666** **Today's Date: _____**

Patient Name:_____ Physician Name:_____

Address:_____ State Lic. #:_____ DEA:_____

City:_____ State:_____ Zip:_____ Name of Practice:_____

Cell:_____ Work: _____ Address:_____

Date of Birth: _____ Sex: M / F City:_____ State:_____ Zip:_____

Weight: _____(lbs/kg) Height: _____ BSA: _____(m^2) Phone:_____ Fax:_____

Allergies: _____ Office Contact: _____

Deliver Rx To:	□ Patient's Home □ Prescriber's Office □ Other: *(please specify)*

Medical History			**Estimated Duration of Therapy:**
	Primary Dx: *(ICD-9)*	*(Description)*	**Date Prescriptions**
	Secondary Dx: *(ICD-9)*	*(Description)*	**Needed in Office:**
	CPT Code:	*(Description)*	

Select from the following commonly used medications: (CMS Guideline Applies – MUST attach recent HgB/HcT lab values)

Drug Name	JCODE	Dose	Quantity	Directions (include route and frequency)	Refills
□ Neupogen (filgrastim)	J1440	300mcg			
□ Neupogen (filgrastim)	J1441	480mcg			
□ Neulasta	J2505				
□ Epogen (ESRD)	J0886				
□ Procrit	J0885				
□ Aranesp	J0881				
□ InFed	J1705				
□ 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)***

TREATMENT REQUEST FORM

CHEMOTHERAPEUTIC AGENTS

Phone Number: 714-364-4008 **Fax Number: 714-364-4666** **Today's Date: _____**

Patient Name:_____ Physician Name:_____

Address:_____ State Lic. #:_____ DEA:_____

City:_____ State:_____ Zip:_____ Name of Practice:_____

Cell:_____ Work: _____ Address:_____

Date of Birth: _____ Sex: M / F City:_____ State:_____ Zip:_____

Weight: _____(lbs/kg) Height: _____ BSA: _____(m^2) Phone:_____ Fax:_____

Allergies: _____ Office Contact: _____

Deliver Rx To:	□ Patient's Home □ Prescriber's Office □ Other: *(please specify)*

Medical History	Primary Dx: *(ICD-9)* *(Description)*	**Current Stage of Cancer:**
	Secondary Dx: *(ICD-9)* *(Description)*	
	CPT Code: *(Description)*	**Estimated Duration of Therapy:**
This is For	□ New Diagnosis and Treatment □ Continuation of Treatment	**Date Prescriptions**
Intent to Treat	□ Adjuvant □ Curative □ Palliative	**Needed in Office:**

Select from the following commonly used medications:

Drug Name	JCODE	Dose	Quantity	Directions (include route and frequency)	Refills
Pre-meds and Anti-Emetics					
□ Diphenhydramine	J1200				
□ Dexamethasone	J1100				
□ Ondansetron	J2405				
□ Granisetron	J1626				
□ Other					
Parenteral Chemotherapy (Please list the chemotherapy regimen below and attach any applicable labs)					
Growth Factor Medications (CMS Guideline Applies – MUST attach recent HgB/HcT lab values)					
□ Neupogen (Filgrastim)	J1440	300mcg			
□ Neupogen (Filgrastim)	J1441	480mcg			
□ Procrit	J0885				
□ Aranesp	J0881				
□ **Unless indicated, Generic Substitution Allowed**					

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

Physician's Signature_____ ***(Physician signature required to validate prescriptions)***

TREATMENT REQUEST FORM

CROHN'S DISEASE

Phone Number: 714-364-4008 **Fax Number: 714-364-4666** **Today's Date: _____**

Patient Name:_____ Physician Name:_____

Address:_____ State Lic. #:_____ DEA:_____

City:_____ State:_____ Zip:_____ Name of Practice:_____

Cell:_____ Work: _____ Address:_____

Date of Birth: _____ Sex: M / F City:_____ State:_____ Zip:_____

Weight: _____(lbs/kg) Height: _____ BSA: _____(m^2) Phone:_____ Fax:_____

Allergies: _____ Office Contact: _____

Deliver Rx To:	□ Patient's Home □ Prescriber's Office □ Other: *(please specify)*

Medical History			**Estimated Duration of Therapy:**
	Primary Dx: *(ICD-9)*	*(Description)*	**Date Prescriptions**
	Secondary Dx: *(ICD-9)*	*(Description)*	**Needed in Office:**
	CPT Code:	*(Description)*	

Select from the following commonly used medications:

Drug Name	JCODE	Dose	Quantity	Directions (include route and frequency)	Refills
□ Remicade	J1745				
□ Humira	J0135				
□ Cimzia	J0718				
□ Tysabri	J2323				
□ 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)***

TREATMENT REQUEST FORM

HEPATITIS C

Phone Number: 714-364-4008 **Fax Number: 714-364-4666** **Today's Date: _____**

Patient Name: _____ Physician Name: _____

Address: _____ State Lic. #: _____ DEA: _____

City: _____ State: _____ Zip: _____ Name of Practice: _____

Cell: _____ Work: _____ Address: _____

Date of Birth: _____ Sex: M / F City: _____ State: _____ Zip: _____

Weight: _____(lbs/kg) Height: _____ BSA: _____(m^2) Phone: _____ Fax: _____

Allergies: _____ Office Contact: _____

Deliver Rx To:	□ Patient's Home □ Prescriber's Office □ Other: *(please specify)*

Medical History	**Diagnosis:** □ 070.54: HepC (Chronic) □ Other ICD-9 _____ **Cirrhosis:** □ Compensated □ Decompensated **Genotype:** □ 1 □ 1a □ 1b □ 2 □ 2a □ 2b □ 3 □ 3a □ 3b □ 4 □ 4a □ 4b □ Other _____
	□ Treatment Naïve □ Previous Treatment _____ **Estimated Duration of Therapy (weeks):**
	□ Non-Responder □ Partial Responder □ Responder/Relapser **Date Prescriptions**
	*****PLEASE FAX ALL HEPATITIS LABORATORY INFORMATION***** **Needed in Office:**

Hepatitis C Combination Therapy (IFN + RBV +/- PI)

□ **PEGASYS®** □ PFS □ Vial (Will dispense as PFS unless noted otherwise) **Qty:** 28 day supply **Refills:** _____
□ 180mcg SQ weekly □ 135mcg SQ weekly □ 90mcg SQ weekly □ Other_____

□ **PEG-INTRON®** □ Redipen □ Vial **Qty:** 28 day supply **Refills:** _____
□ Pediatric (3-17yrs): 60 mcg/m^2/wk _____mcg SQ weekly (**Note:** BSA Dosing)
□ Adult: 1.5 mcg/kg/wk (Select dose below)

Pounds	Kilogram	Strength	PEG-INTRON (mcg/ml)
Less than 88	Less than 40	50mcg / 0.5ml	□ 50mcg (0.5 ml) SQ weekly
88 – 111 112 – 133	40 – 50 51 – 60	80 mcg / 0.5ml	□ 64 mcg (0.4 ml) SQ weekly □ 80 mcg (0.5 ml) SQ weekly
134 – 166 167 – 187	61 – 75 76 – 85	120 mcg / 0.5ml	□ 96 mcg (0.4 ml) SQ weekly □ 120 mcg (0.5ml) SQ weekly
188 – 231	86 – 105	150 mcg / 0.5ml	□ 150 mcg (0.5ml) SQ weekly
Greater than 231	Greater than 105	□ 1.5 mcg/kg/wk _____mcg SQ weekly (nearest available dose)	

□ **RIBAVIRIN** □ Ribavirin 200mg caps □ RIBAPAK® (Ribavirin Dose Pack) **Qty:** 28 day supply **Refills:** _____

Pounds	Kilogram	Drug Dosing
Less than 145	Less than 66	□ 800mg: 400 mg tab QAM; 400 mg tab QPM
145 – 177	66 – 80	□ 1000mg: 600 mg tab QAM; 400 mg tab QPM
178 – 231	81 - 105	□ 1200mg: 600 mg tab QAM; 600 mg tab QPM
Greater than 231	Greater than 105	□ 1400 mg: 800 mg tab QAM; 600 mg tab QPM *If RIBAPAK® is dispensed:* 600 mg RIBAPAK® tab QAM + ribavirin 200mg QAM; 600 mg RIBAPAK® tab QPM

□ **Other Ribavirin dosing:**

□ **INCIVEK® (telaprevir) 375mg tab**
Dosage: 750 mg (2 x 375mg) po TID (7 to 9 hours) with non-low fat meal
Qty: 28 day supply **Refills:** _____

□ **VICTRELIS® (boceprevir) 200 mg caps***
Dosage: 800 mg (4 x 200mg) po TID (7 to 9 hours)
*Requires 4 week lead in of interferon-alfa and ribavirin
Qty: 28 day supply **Refills:** _____

□ **Others:**

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

Physician's Signature_____ ***(Physician signature required to validate prescriptions)***

TREATMENT REQUEST FORM

MULTIPLE SCLEROSIS

Phone Number: 714-364-4008 **Fax Number: 714-364-4666** **Today's Date: _____**

Patient Name:_____ Physician Name:_____

Address:_____ State Lic. #:_____ DEA:_____

City:_____ State:_____ Zip:_____ Name of Practice:_____

Cell:_____ Work: _____ Address:_____

Date of Birth: _____ Sex: M / F City:_____ State:_____ Zip:_____

Weight: _____(lbs/kg) Height: _____ BSA: _____(m^2) Phone:_____ Fax:_____

Allergies: _____ Office Contact: _____

Deliver Rx To:	□ Patient's Home □ Prescriber's Office □ Other: *(please specify)*

Medical History	Primary Dx: *(ICD-9)*	*(Description)*	**Estimated Duration of Therapy:**
	Secondary Dx: *(ICD-9)*	*(Description)*	**Date Prescriptions Needed in Office:**
	CPT Code:	*(Description)*	

Select from the following commonly used medications:

Drug Name	JCODE	Dose	Quantity	Directions (include route and frequency)	Refills
□ Avonex (IFN β-1a)					
□ Betaseron (IFN β-1b)					
□ Copaxone					
□ Rebif					
□ Tysabri					
□ 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)***

TREATMENT REQUEST FORM

OSTEOARTHRITIS

Phone Number: 714-364-4008 **Fax Number: 714-364-4666** **Today's Date: _____**

Patient Name:_____ Physician Name:_____

Address:_____ State Lic. #:_____ DEA:_____

City:_____ State:_____ Zip:_____ Name of Practice:_____

Cell:_____ Work: _____ Address:_____

Date of Birth: _____ Sex: M / F City:_____ State:_____ Zip:_____

Weight: _____(lbs/kg) Height: _____ BSA: _____(m^2) Phone:_____ Fax:_____

Allergies: _____ Office Contact: _____

Deliver Rx To:	□ Patient's Home □ Prescriber's Office □ Other: *(please specify)*

Medical History			**Estimated Duration of Therapy:**
	Primary Dx: *(ICD-9)*	*(Description)*	**Date Prescriptions**
	Secondary Dx: *(ICD-9)*	*(Description)*	**Needed in Office:**
	CPT Code:	*(Description)*	

Select from the following commonly used medications:

Drug Name	JCODE	Dose	Quantity	Directions (include route and frequency)	Refills
□ Hyalgan	J7321				
□ Synvisc	J7325				
□ Orthovisc	J7324				
□ Euflexxa	J7323				
□ Stelara	J3357				
□ Others					
□ **Unless indicated, Generic Substitution Allowed**					

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

Physician's Signature_____ ***(Physician signature required to validate prescriptions)***

TREATMENT REQUEST FORM

OSTEOPOROSIS

Phone Number: 714-364-4008 **Fax Number: 714-364-4666** **Today's Date: _____**

Patient Name:_____ Physician Name:_____

Address:_____ State Lic. #:_____ DEA:_____

City:_____ State:_____ Zip:_____ Name of Practice:_____

Cell:_____ Work: _____ Address:_____

Date of Birth: _____ Sex: M / F City:_____ State:_____ Zip:_____

Weight: _____(lbs/kg) Height: _____ BSA: _____(m^2) Phone:_____ Fax:_____

Allergies: _____ Office Contact: _____

Deliver Rx To:	□ Patient's Home □ Prescriber's Office □ Other: *(please specify)*

Medical History	Primary Dx: *(ICD-9)* *(Description)*	**T-score: _____**
	Secondary Dx: *(ICD-9)* *(Description)*	**Location of T-score test:**
	CPT Code: *(Description)*	**Estimated Duration of Therapy:**
	Tried and failed Bisphosphonates: □ No □ Yes (specify:)	**Date Prescriptions Needed in Office:**

Select from the following commonly used medications:

Drug Name	JCODE	Dose	Quantity	Directions (include 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)***

TREATMENT REQUEST FORM

PSORIASIS

Phone Number: 714-364-4008 **Fax Number: 714-364-4666** **Today's Date: _____**

Patient Name:_____ Physician Name:_____

Address:_____ State Lic. #:_____ DEA:_____

City:_____ State:_____ Zip:_____ Name of Practice:_____

Cell:_____ Work: _____ Address:_____

Date of Birth: _____ Sex: M / F City:_____ State:_____ Zip:_____

Weight: _____(lbs/kg) Height: _____ BSA: _____(m^2) Phone:_____ Fax:_____

Allergies: _____ Office Contact: _____

Deliver Rx To:	□ Patient's Home □ Prescriber's Office □ Other: *(please specify)*

Medical History			**Estimated Duration of Therapy:**
	Primary Dx: *(ICD-9)*	*(Description)*	**Date Prescriptions**
	Secondary Dx: *(ICD-9)*	*(Description)*	**Needed in Office:**
	CPT Code:	*(Description)*	

Select from the following commonly used medications:

Drug Name	JCODE	Dose	Quantity	Directions (include route and frequency)	Refills
□ Enbrel	J1438				
□ Remicade	J1745				
□ Humira	J0135				
□ Simponi	J3590				
□ Amevive	J0215				
□ Stelara	J3357				
□ 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)***

TREATMENT REQUEST FORM

RHEUMATOID ARTHRITIS

Phone Number: 714-364-4008 **Fax Number: 714-364-4666** **Today's Date: _____**

Patient Name:_____ Physician Name:_____

Address:_____ State Lic. #:_____ DEA:_____

City:_____ State:_____ Zip:_____ Name of Practice:_____

Cell:_____ Work: _____ Address:_____

Date of Birth: _____ Sex: M / F City:_____ State:_____ Zip:_____

Weight: _____(lbs/kg) Height: _____ BSA: _____(m^2) Phone:_____ Fax:_____

Allergies: _____ Office Contact: _____

Deliver Rx To:	□ Patient's Home □ Prescriber's Office □ Other: *(please specify)*

Medical History		
	Primary Dx: *(ICD-9)* *(Description)*	Severity of RA: □ Mild □ Moderate □ Severe
	Secondary Dx: *(ICD-9)* *(Description)*	Tried and failed, or contraindicated to MTX? □ Yes □ No
	CPT Code: *(Description)*	**Estimated Duration of Therapy:**
	Tried and failed DMARDS? □ No □ Yes (specify below) □ Plaquenil □ Azulfidine □ Imuran □ Neoral □ Other:	**Date Prescriptions Needed in Office:**

Select from the following commonly used medications:

Drug Name	JCODE	Dose	Quantity	Directions (include route and frequency)	Refills
□ Humira	J0135				
□ Enbrel	J1438				
□ Remicade	J1745				
□ Cimzia	J0718				
□ Simponi	J3590				
□ Rituxan	J9310				
□ Actemra	J3262				
□ Kineret	J3490				
□ Others					

□ **Unless indicated, Generic Substitution Allowed**

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

Physician's Signature_____ ***(Physician signature required to validate prescriptions)***