EmblemHealth

Magellan Rx MANAGEMENT

Chemotherapy Order Form For HIP Drug Replacement Program

Use form when ordering drugs that also require prior approval

Today's Date: ___/____/_____ **Date of Service** ____/____/____

Fax to: Magellan Rx Management 1-888-656-6671

☐ **Urgent**

PATIENT INFORMATION (PRINT)

Patient Name:	Date of Birth:	
Patient Address:	Apt/Suite:	
City:	State:	ZIP:
Patient Phone Number:	E- address:	
Member Identification ber:	Secondary Insurance:	

FACILITY/PROVIDER IPPING DDRESS AND OFFICE NAME (PRINT)

Please check days that office ed: ☐ MON ☐ TUE ☐ WED ☐ THU ☐ FR ☐ SAT ☐ SUN

Contact Person:	Contact Person E-mail Address:	
Office Name:	one Number:	Fax Number:
Address *(No P .O. Box)*:		Apt/ Suite:
City:	State	ZIP
MD License Number:	MD NPI Number:	MD DEA Number:
Physician Name *(print)*:		
MD Signature *(Signature required. No stamps please.)*:		

For NY, Magellan Rx Management is required to obta copy of an official

BSA(m2):	Pat t He cm	Patient Weight: kg
Primary ICD-9 Code:	Sec y DX:	
*Hgb Level: Gm/DI	HCT Level: %	
**ANC Level: /mm3	***Scr:	
****Her2:	*****KRAS Mutated: ☐ Yes ☐ No	
Ferritin Level: ng/ml	TSAT %	Last Aranesp dose given _____/_____/_____
Date most current lab work: _____/_____/_____ *(Labs may be requested if necessary.)*		
☐ Allergies ☐ NKA	Other *(list)*	

Drugs	Strength/Frequency	Drugs	Strength/Frequency
Note: Drugs with asterisks indicate specific test results *(see above)* that must be submitted when requesting a prior approval.			
Aloxi		Neupogen **	
Abraxane		Neulasta **	
Alimta		Procrit *	
Aranesp*		Provenge	
Avastin		Rituxan	
Erbitux*****		Vectibix *****	
Herceptin ****		Zoledronic acid	
Leukine **			

Additional Drugs	Strength/Frequency	Additional Drugs	Strength/Frequency

DO NOT USE

Medications listed in the table above require prior approval by Magellan Rx Management. Please fax the completed form to Magellan Rx Management at **1-888-656-6671**.
Please call **1-800-424-4084** with any questions.