EmblemHealth

Magellan Rx MANAGEMENT

Injectable Order Form For HIP Drug Replacement Program

Use form when ordering drugs that also require prior approval

☐ **Urgent**

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

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

PATIENT INFORMATION (PRINT)

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

FACILITY/PROVIDER SHIPPING ADDRESS AND OFFICE NAME (PRINT)

Please check days that office is closed: ☐ MON ☐ TUE ☐ WED ☐ THU ☐ FRI ☐ SAT ☐ SUN

Contact Person:	Contact Person E-mail address:	
Office Name:	Phone 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 obtain a copy of an official NY Rx.

BSA(m2)	Patient Height cm	Patient Weight kg
Primary ICD-9 Code	Secondary DX	
*Hgb Level Gm/DI	HCT Level %	
CrCl	**Creat	
PLT	Other	
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.			
Aranesp*		Procrit*	
Botox		Remicade	
Epogen*		Rituxan	
IVIG (specify) _____		Sandostatin	
		Soliris	
Myobloc		Vantas	
Orencia (IV)		Zoledronic acid	
Additional Drugs	**Strength/Frequency**	**Additional Drugs**	**Strength/Frequency**

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.