



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-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 NYS Rx.

BSA (m2):	Patient Height: cm	Patient Weight: kg
Primary ICD-9 Code:	Secondary DX:	
*Hgb Level: Gm/DI	HCT Level: %	
ANC Level: /mm3	*Scr:	
****Her2:	*****KRAS Mutated: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Ferritin Level: ng/ml	TSAT %	Last Aranesp dose given ___/___/___
Date most current lab work: ___/___/___ (Labs may be requested if necessary.)		
<input type="checkbox"/> Allergies <input type="checkbox"/> NKA	Other (list)	

Drugs	Strength/Frequency	Drugs	Strength/Frequency
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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*		Proveng	
Avastin		Rituxan	
Erbitux*****		Vectibix *****	
Herceptin ****		Zoledronic acid	
Leukine **			

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.