



Injectable 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 (m ²)	Patient Height	cm	Patient Weight	kg
Primary ICD-9 Code		Secondary DX		
*Hgb Level	Gm/Dl	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.)				
<input type="checkbox"/> Allergies <input type="checkbox"/> 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	
IVIIG (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.