UHC – MEDICATION SOURCING EXPANSION PRESCRIBER ORDER FORM

Fax completed form and clinical documentation to (888) 979-8904. Call (833) 730-HOPD (4673) with any questions/concerns.

option care health™

Patient Name:			**Date of Birth:**	
Address:				
Phone:	**Height:**	☐ inches ☐ cm	**Weight:**	☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:	**ICD-10 Code:**

Prescription Order

Please select the medication(s) to be dispensed along with the intended dose to be administered.

Inflammatory Conditions
- ☐ Remicade®: _____ mg
- ☐ Entyvio®: ___300___ mg
- ☐ Actemra®: _____ mg
- ☐ Orencia®: _____ mg
- ☐ Simponi Aria®: _____ mg
- ☐ Inflectra®: _____ mg
- ☐ Renflexis®: _____ mg
- ☐ Stelara®: _____ mg
- ☐ Avsola®: _____ mg

Enzyme Replacement Therapy
- ☐ Cerezyme®: _____ mg
- ☐ VPRIV®: _____ mg
- ☐ Fabrazyme®: _____ mg
- ☐ Lumizyme®: _____ mg
- ☐ Aldurazyme®: _____ mg
- ☐ Kanuma®: _____ mg
- ☐ Elaprase®: _____ mg
- ☐ Naglazyme®: _____ mg

Alpha-1 Proteinase Inhibitors
- ☐ Glassia®: _____ mg
- ☐ Zemaira®: _____ mg

Multiple Sclerosis
- ☐ Ocrevus®: _____ mg
- ☐ Tysabri®: ___300___ mg

Endocrine
- ☐ Tepezza®: _____ mg

Immune Globulin
- ☐ Gammaplex® 10%: _____ gm
- ☐ Gammaplex® 5%: _____ gm
- ☐ Gammagard® 10%: _____ gm
- ☐ Octagam® 10%: _____ gm
- ☐ Octagam® 5%: _____ gm
- ☐ Privigen®: _____ gm
- ☐ Hizentra®: _____ gm
- ☐ Cutaquig®: _____ gm
- ☐ Cuvitru®: _____ gm
- ☐ Panzyga®: _____ gm
- ☐ Gamunex®-C: _____ gm
- ☐ Gammaked®: _____ gm
- ☐ HyQvia®: _____ gm

Duchenne Muscular Dystrophy
- ☐ Exondys 51®: _____ mg
- ☐ Vyondys 53®: _____ mg

HIV
- ☐ Trogarzo®: _____ mg

Monoclonal Antibody, Complement Inhibitor
- ☐ Soliris®: _____ mg
- ☐ Ultomiris®: _____ mg

Monoclonal Antibody, Miscellaneous
- ☐ Benlysta®: _____ mg

CNS Agents
- ☐ Radicava®: ____60____ mg
- ☐ Vyepti®: _____ mg

Prescriber to clinically manage patients – pharmacy to dispense medication only.

All non-immune globulin medications will be rounded up to the nearest whole vial size.

All immune globulin medications will be rounded up to the nearest whole vial size based on market availability (i.e. dispensed vial sizes may be adjusted based on backorders.

Directions for Use: For preparation (as applicable) and administration at prescriber's designated site of care.

Frequency of Dispense Requested to Prescriber Office: _____

Refills Authorized: _____ **Date of Next Dose:** _____

Ancillary Supplies: Check here if any applicable diluent and/or dilution bag should be provided with the medication(s) selected above – ☐

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

Prescriber Information

Prescriber Name:	**NPI:**

Site of Care (Delivery Address)

Facility/Practice Name:			**Attention To:**
Address:			
City:	**State:**	**Zip:**	**Phone:**

