

UHC – MEDICATION SOURCING ONCOLOGY PRESCRIBER ORDER FORM

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



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.

Filgrastim Biosimilars

- Granix® (tbo-filgrastim): _____ mg
- Nivestym® (filgrastim-aafi): _____ mg
- Zarxio® (filgrastim-sndz): _____ mg

Pegfilgrastim Biosimilars

- Fulphila® (pegfilgrastim-jmdb): _____ mg
- Nyvepria™ (pegfilgrastim-apgf): _____ mg
- Udenyca® (pegfilgrastim-cbqv): _____ mg
- Ziextenzo® (pegfilgrastim-bmez): _____ mg

Bone-Modifying Monoclonal Antibody

- Xgeva® (denosumab): _____ mg

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

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:

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