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.

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.

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:**

