

# BONE MARROW TRANSPLANT REFERRAL FORM

## PATIENT INFORMATION (please attach insurance card)

|         |        |                                                       |      |             |
|---------|--------|-------------------------------------------------------|------|-------------|
| Name:   |        | <input type="checkbox"/> M <input type="checkbox"/> F | DoB: |             |
| Street: |        | City:                                                 |      | State: Zip: |
| Phone:  | Phone: | Allergies:                                            |      |             |

## CLINICAL INFORMATION (please attach clinical notes and labs)

**Diagnosis with ICD-10 code**

☐ **B25.9** cytomegalovirus (CMV) prophylaxis and/or treatment ☐ **D89.813** graft-versus-host disease (GVHD)

☐ **B44.9** *Aspergillus* (circle one) prophylaxis/treatment ☐ Other: \_\_\_\_\_

☐ **K76.5** prevention of hepatic sinusoidal obstruction syndrome associated with stem cell transplant

**height:** \_\_\_\_\_ **weight:** \_\_\_\_\_ kg **Labs** (please attach most recent results): ☐ CMP ☐ CMV level

Current medication(s) with date(s) started: \_\_\_\_\_

Prior medication(s) with date(s) of use: \_\_\_\_\_

## PRESCRIPTION

☐ **DAW** (deliver to ☐ patient ☐ office)

| Medication                                                        | Dose/Strength                                                                                                                                                                            | Directions/Sig | Quantity | Refills |
|-------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|----------|---------|
| <input type="checkbox"/> cyclosporine, modified (Gengraf, Neoral) | <b>Caps:</b> <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> 100mg<br><b>Soln:</b> <input type="checkbox"/> 100mg/mL                                |                |          |         |
| <input type="checkbox"/> cyclosporine, non-modified (SandIMMUNE)  | <b>Caps:</b> <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> 100mg<br><b>Soln:</b> <input type="checkbox"/> 100mg/mL                                |                |          |         |
| <input type="checkbox"/> tacrolimus                               | <b>Caps:</b> <input type="checkbox"/> 0.5mg <input type="checkbox"/> 1mg <input type="checkbox"/> 5mg                                                                                    |                |          |         |
| <input type="checkbox"/> ursodiol                                 | <b>Caps:</b> <input type="checkbox"/> 200mg <input type="checkbox"/> 300mg <input type="checkbox"/> 400mg<br><b>Tabbs:</b> <input type="checkbox"/> 250mg <input type="checkbox"/> 500mg |                |          |         |

### Prophylaxis and/or Treatment, *Aspergillus*

|                                       |                                                                                                                             |                                                                                                                                        |  |  |
|---------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|--|--|
| <input type="checkbox"/> Cresemba     | <b>Caps:</b> <input type="checkbox"/> 74.5mg <input type="checkbox"/> 186mg                                                 | <input type="checkbox"/> <b>Initiation:</b> 372mg PO Q8h x 6 doses<br><input type="checkbox"/> <b>Maintenance:</b> 372mg PO once daily |  |  |
| <input type="checkbox"/> posaconazole | <b>Susp:</b> <input type="checkbox"/> 40mg/mL<br><b>Tabbs:</b> <input type="checkbox"/> 100mg                               |                                                                                                                                        |  |  |
| <input type="checkbox"/> voriconazole | <b>Susp:</b> <input type="checkbox"/> 40mg/mL<br><b>Tabbs:</b> <input type="checkbox"/> 50mg <input type="checkbox"/> 200mg |                                                                                                                                        |  |  |

### Prophylaxis and/or Treatment, CMV

|                                                   |                                                                                               |                                       |  |  |
|---------------------------------------------------|-----------------------------------------------------------------------------------------------|---------------------------------------|--|--|
| <input type="checkbox"/> Livtency                 | 200mg tablet                                                                                  | 400mg PO twice daily for _____ weeks  |  |  |
| <input type="checkbox"/> Prevymis                 | <b>Tabbs:</b> <input type="checkbox"/> 240mg <input type="checkbox"/> 480mg                   | _____mg PO once daily for _____ weeks |  |  |
| <input type="checkbox"/> valganciclovir (Valcyte) | <b>Soln:</b> <input type="checkbox"/> 50mg/mL<br><b>Tabbs:</b> <input type="checkbox"/> 450mg |                                       |  |  |
| <b>Other:</b>                                     |                                                                                               |                                       |  |  |

## PRESCRIBER INFORMATION

|               |                                                                                                             |                        |      |  |
|---------------|-------------------------------------------------------------------------------------------------------------|------------------------|------|--|
| Prescriber:   |                                                                                                             | Supervising Physician: |      |  |
| Contact Name: | Contact Method: <input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Email: |                        |      |  |
| Phone:        | Ext:                                                                                                        | Fax:                   |      |  |
| Street:       | City:                                                                                                       | State:                 | Zip: |  |
| Signature:    | Date:                                                                                                       | NPI:                   |      |  |

# BONE MARROW TRANSPLANT REFERRAL FORM (GCSF)

Phone: 404-585-7517  
Fax: 404-900-9209  
NPI: 1811550528  
synergengerx.com

## PATIENT INFORMATION (please attach insurance card)

|         |        |                                                       |        |      |
|---------|--------|-------------------------------------------------------|--------|------|
| Name:   |        | <input type="checkbox"/> M <input type="checkbox"/> F | DoB:   |      |
| Street: |        | City:                                                 | State: | Zip: |
| Phone:  | Phone: | Allergies:                                            |        |      |

## CLINICAL INFORMATION (please attach clinical notes and labs)

|                                                                                                 |                                                                                                                 |                         |
|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|-------------------------|
| <b>Diagnosis with ICD-10 code</b>                                                               | <input type="checkbox"/> <b>C92.A0</b> acute myeloid leukemia following induction or consolidation chemotherapy | <b>height:</b> _____    |
|                                                                                                 | <input type="checkbox"/> <b>D75.9</b> chemotherapy-induced myelosuppression in nonmyeloid malignancies          |                         |
|                                                                                                 | <input type="checkbox"/> <b>D46.9</b> myelodysplastic syndromes with anemia                                     | <b>weight:</b> _____ kg |
|                                                                                                 | <input type="checkbox"/> <b>D61.03</b> Fanconi anemia-associated neutropenia                                    |                         |
| <input type="checkbox"/> <b>D70.1</b> prevention of chemotherapy-induced neutropenia            |                                                                                                                 |                         |
| <input type="checkbox"/> <b>D70.9</b> severe chronic neutropenia                                |                                                                                                                 |                         |
| <input type="checkbox"/> <b>T66.XXXA</b> hematopoietic radiation injury syndrome, acute         |                                                                                                                 |                         |
| <input type="checkbox"/> <b>Z94.81</b> bone marrow transplantation                              |                                                                                                                 |                         |
| <input type="checkbox"/> <b>Z94.84</b> hematopoietic cell mobilization for apheresis collection |                                                                                                                 |                         |
| <input type="checkbox"/> Other: _____                                                           |                                                                                                                 |                         |

**Labs** (please attach most recent results):

- ☐ CBC with differential  
☐ ANC: \_\_\_\_\_ cells/mcL

Current medication(s) with date(s) started: \_\_\_\_\_

Prior medication(s) with date(s) of use: \_\_\_\_\_

## PRESCRIPTION

☐ **DAW** (deliver to ☐ patient ☐ office)

| Medication                                          | Dose/Strength                                                                                                                                                                    | Directions/Sig | Quantity | Refills |
|-----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|----------|---------|
| <input type="checkbox"/>                            | Check this box to authorize the pharmacy to interchange to the plan's preferred biosimilar if needed                                                                             |                |          |         |
| <input type="checkbox"/> Granix<br>(tbo-filgrastim) | <b>PFS:</b> <input type="checkbox"/> 300mcg/0.5mL <input type="checkbox"/> 480mcg/0.8mL<br><b>Soln:</b> <input type="checkbox"/> 300mcg/mL <input type="checkbox"/> 480mcg/1.6mL |                |          |         |
| <input type="checkbox"/> Nivestym<br>(filgrastim)   | <b>PFS:</b> <input type="checkbox"/> 300mcg/0.5mL <input type="checkbox"/> 480mcg/0.8mL<br><b>Soln:</b> <input type="checkbox"/> 300mcg/mL <input type="checkbox"/> 480mcg/1.6mL |                |          |         |
| <input type="checkbox"/> Releuko<br>(filgrastim)    | <b>PFS:</b> <input type="checkbox"/> 300mcg/0.5mL <input type="checkbox"/> 480mcg/0.8mL<br><b>Soln:</b> <input type="checkbox"/> 300mcg/mL <input type="checkbox"/> 480mcg/1.6mL |                |          |         |

### Pegfilgrastim (extended interval)

|                                   |                                                                                                  |  |  |  |
|-----------------------------------|--------------------------------------------------------------------------------------------------|--|--|--|
| <input type="checkbox"/> Fulphila | 6mg/0.6mL PFS                                                                                    |  |  |  |
| <input type="checkbox"/> Fylnetra | 6mg/0.6mL PFS                                                                                    |  |  |  |
| <input type="checkbox"/> Nyvepria | 6mg/0.6mL PFS                                                                                    |  |  |  |
| <input type="checkbox"/> Udenyca  | <b>Pen:</b> <input type="checkbox"/> 6mg/0.6mL<br><b>PFS:</b> <input type="checkbox"/> 6mg/0.6mL |  |  |  |

### Ancillary

|                                           |                                                     |   |  |
|-------------------------------------------|-----------------------------------------------------|---|--|
| <input type="checkbox"/> alcohol swabs    | use to clean injection site prior to each injection |   |  |
| <input type="checkbox"/> sharps container | use to dispose of syringes after each injection     | 1 |  |
| <b>Other:</b>                             |                                                     |   |  |

## PRESCRIBER INFORMATION

|               |                                                                                                             |                        |      |
|---------------|-------------------------------------------------------------------------------------------------------------|------------------------|------|
| Prescriber:   |                                                                                                             | Supervising Physician: |      |
| Contact Name: | Contact Method: <input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Email: |                        |      |
| Phone:        | Ext:                                                                                                        | Fax:                   |      |
| Street:       | City:                                                                                                       | State:                 | Zip: |
| Signature:    | Date:                                                                                                       | NPI:                   |      |

\*By signing this form, I authorize Synergen Rx LLC and its employees to act as authorized agents on behalf of my office to obtain prior authorization through my patient's insurance plan and to facilitate the enrollment of the patient into patient assistance programs with manufacturers and other foundations.