SYNERGEN Rx Specialty Pharmacy

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

BONE MARROW TRANSPLANT REFERRAL FORM

PATIENT INFORMATION (please attach insurance card)

Name: ☐ M ☐ 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
- ☐ **B44.9** *Aspergillus (circle one)* prophylaxis/treatment
- ☐ **K76.5** prevention of hepatic sinusoidal obstruction syndrome associated with stem cell transplant
- ☐ **D89.813** graft-versus-host disease (GVHD)
- ☐ Other:

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*
☐ cyclosporine, modified (Gengraf, Neoral)	**Caps**: ☐ 25mg ☐ 50mg ☐ 100mg **Soln**: ☐ 100mg/mL			
☐ cyclosporine, non-modified (SandIMMUNE)	**Caps**: ☐ 25mg ☐ 50mg ☐ 100mg **Soln**: ☐ 100mg/mL			
☐ tacrolimus	**Caps**: ☐ 0.5mg ☐ 1mg ☐ 5mg			
☐ ursodiol	**Caps**: ☐ 200mg ☐ 300mg ☐ 400mg **Tabs**: ☐ 250mg ☐ 500mg			
Prophylaxis and/or Treatment, *Aspergillus*				
☐ Cresemba	**Caps**: ☐ 74.5mg ☐ 186mg	☐ **Initiation**: 372mg PO Q8h x 6 doses ☐ **Maintenance**: 372mg PO once daily		
☐ posaconazole	**Susp**: ☐ 40mg/mL **Tabs**: ☐ 100mg			
☐ voriconazole	**Susp**: ☐ 40mg/mL **Tabs**: ☐ 50mg ☐ 200mg			
Prophylaxis and/or Treatment, CMV				
☐ Livtencity	200mg tablet	400mg PO twice daily for ____ weeks		
☐ Prevymis	**Tabs**: ☐ 240mg ☐ 480mg	____mg PO once daily for ____ weeks		
☐ valacyclovir	**Tabs**: ☐ 500mg ☐ 1g			
☐ valganciclovir (Valcyte)	**Soln**: ☐ 50mg/mL **Tabs**: ☐ 450mg			
Other:				

PRESCRIBER INFORMATION

Prescriber: Supervising Physician:

Contact Name: Contact Method: ☐ Phone ☐ Fax ☐ 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.

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BONE MARROW TRANSPLANT REFERRAL FORM (GCSF)

PATIENT INFORMATION (please attach insurance card)

Name: ☐ M ☐ F DoB:

Street: City: State: Zip:

Phone: Phone: Allergies:

CLINICAL INFORMATION (please attach clinical notes and labs)

Diagnosis with ICD-10 code

- ☐ **C92.A0** acute myeloid leukemia following induction or consolidation chemotherapy
- ☐ **D75.9** chemotherapy-induced myelosuppression in nonmyeloid malignancies
- ☐ **D46.9** myelodysplastic syndromes with anemia
- ☐ **D61.03** Fanconi anemia-associated neutropenia
- ☐ **D70.1** prevention of chemotherapy-induced neutropenia
- ☐ **D70.9** severe chronic neutropenia
- ☐ **T66.XXXA** hematopoietic radiation injury syndrome, acute
- ☐ **Z94.81** bone marrow transplantation
- ☐ **Z94.84** hematopoietic cell mobilization for apheresis collection
- ☐ Other:

height: _____

weight: _____ kg

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*
☐	*Check this box to authorize the pharmacy to interchange to the plan's preferred biosimilar if needed*			
☐ Granix (*tbo-filgrastim*)	**PFS:** ☐ 300mcg/0.5mL ☐ 480mcg/0.8mL **Soln:** ☐ 300mcg/mL ☐ 480mcg/1.6mL			
☐ Nivestym (*filgrastim*)	**PFS:** ☐ 300mcg/0.5mL ☐ 480mcg/0.8mL **Soln:** ☐ 300mcg/mL ☐ 480mcg/1.6mL			
☐ Releuko (*filgrastim*)	**PFS:** ☐ 300mcg/0.5mL ☐ 480mcg/0.8mL **Soln:** ☐ 300mcg/mL ☐ 480mcg/1.6mL			
Pegfilgrastim (extended interval)				
☐ Fulphila	6mg/0.6mL PFS			
☐ Fylnetra	6mg/0.6mL PFS			
☐ Nyvepria	6mg/0.6mL PFS			
☐ Udenyca	**Pen**: ☐ 6mg/0.6mL **PFS**: ☐ 6mg/0.6mL			
Ancillary				
☐ alcohol swabs		use to clean injection site prior to each injection		
☐ sharps container		use to dispose of syringes after each injection	1	
Other:				

PRESCRIBER INFORMATION

Prescriber: Supervising Physician:

Contact Name: Contact Method: ☐ Phone ☐ Fax ☐ Email:

Phone: Ext: Fax:

Street: City: State: Zip:

Signature: Date: NPI:

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