



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  **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 <b>Solin:</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 <b>Solin:</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 <b>Tab:</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 <input type="checkbox"/> <b>Maintenance:</b> 372mg PO once daily		
<input type="checkbox"/> posaconazole	<b>Susp:</b> <input type="checkbox"/> 40mg/mL <b>Tab:</b> <input type="checkbox"/> 100mg			
<input type="checkbox"/> voriconazole	<b>Susp:</b> <input type="checkbox"/> 40mg/mL <b>Tab:</b> <input type="checkbox"/> 50mg <input type="checkbox"/> 200mg			

### Prophylaxis and/or Treatment, CMV

<input type="checkbox"/> Livtensity	200mg tablet	400mg PO twice daily for _____ weeks		
<input type="checkbox"/> Prevymis	<b>Tab:</b> <input type="checkbox"/> 240mg <input type="checkbox"/> 480mg	_____ mg PO once daily for _____ weeks		
<input type="checkbox"/> valacyclovir	<b>Tab:</b> <input type="checkbox"/> 500mg <input type="checkbox"/> 1g			
<input type="checkbox"/> valganciclovir (Valcyte)	<b>Solin:</b> <input type="checkbox"/> 50mg/mL <b>Tab:</b> <input type="checkbox"/> 450mg			
<b>Other:</b>				

## 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.



# BONE MARROW TRANSPLANT REFERRAL FORM (GCSF)

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## 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 <input type="checkbox"/> <b>D75.9</b> chemotherapy-induced myelosuppression in nonmyeloid malignancies <input type="checkbox"/> <b>D46.9</b> myelodysplastic syndromes with anemia <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: _____	<b>height:</b> _____  <b>weight:</b> _____ kg
	<b>Labs (please attach most recent results):</b> <input type="checkbox"/> CBC with differential <input type="checkbox"/> 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"/>	<i>Check this box to authorize the pharmacy to interchange to the plan's preferred biosimilar if needed</i>			
<input type="checkbox"/> Granix (tbo-filgrastim)	<b>PFS:</b> <input type="checkbox"/> 300mcg/0.5mL <input type="checkbox"/> 480mcg/0.8mL <b>Soln:</b> <input type="checkbox"/> 300mcg/mL <input type="checkbox"/> 480mcg/1.6mL			
<input type="checkbox"/> Nivestym (filgrastim)	<b>PFS:</b> <input type="checkbox"/> 300mcg/0.5mL <input type="checkbox"/> 480mcg/0.8mL <b>Soln:</b> <input type="checkbox"/> 300mcg/mL <input type="checkbox"/> 480mcg/1.6mL			
<input type="checkbox"/> Releuko (filgrastim)	<b>PFS:</b> <input type="checkbox"/> 300mcg/0.5mL <input type="checkbox"/> 480mcg/0.8mL <b>Soln:</b> <input type="checkbox"/> 300mcg/mL <input type="checkbox"/> 480mcg/1.6mL			
<b>Pegfilgrastim (extended interval)</b>				
<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 <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:	

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# SOLID ORGAN TRANSPLANT REFERRAL FORM (immunosuppression)

## 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**

<input type="checkbox"/> <b>B25.9</b> cytomegalovirus (CMV) prophylaxis and/or treatment	<input type="checkbox"/> <b>Z94.0</b> kidney replaced by transplant	<input type="checkbox"/> Other: _____
<input type="checkbox"/> <b>B44.9</b> <i>Aspergillus</i> prophylaxis and/or treatment	<input type="checkbox"/> <b>Z94.2</b> lung replaced by transplant	<input type="checkbox"/> Other: _____
<input type="checkbox"/> <b>B59</b> Pneumocystis PNA (PCP/PJP) prophylaxis and/or treatment	<input type="checkbox"/> <b>Z94.3</b> heart replaced by transplant	<input type="checkbox"/> Other: _____
	<input type="checkbox"/> <b>Z94.4</b> liver replaced by transplant	<input type="checkbox"/> Other: _____

**Date of transplant:** \_\_\_\_\_ **Labs (please attach most recent results):**  CMP  CMV level  C&S report(s)

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"/> <b>transplant bag</b>	Check here for BP monitor, thermometer, sunscreen, lip balm, pill splitter, pill organizer, hand sanitizer, & masks			
<b>Immunosuppression</b>				
<input type="checkbox"/> azathioprine	<b>Tabs:</b> <input type="checkbox"/> 50mg <input type="checkbox"/> 75mg <input type="checkbox"/> 100mg			
<input type="checkbox"/> cyclosporine, modified (Gengraf, Neoral)	<b>Caps:</b> <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> 100mg <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 <b>Soln:</b> <input type="checkbox"/> 100mg/mL			
<input type="checkbox"/> Envarsus	<b>Tabs:</b> <input type="checkbox"/> 1mg <input type="checkbox"/> 4mg			
<input type="checkbox"/> everolimus (Zortress)	<b>Tabs:</b> <input type="checkbox"/> 0.25mg <input type="checkbox"/> 0.5mg <input type="checkbox"/> 0.75mg <input type="checkbox"/> 1mg			
<input type="checkbox"/> mycophenolate mofetil (Cellcept)	<b>Caps:</b> <input type="checkbox"/> 250mg <b>Tabs:</b> <input type="checkbox"/> 500mg			
<input type="checkbox"/> mycophenolic acid (Myfortic)	<b>Tabs:</b> <input type="checkbox"/> 180mg <input type="checkbox"/> 360mg			
<input type="checkbox"/> prednisone	<b>Tabs:</b> <input type="checkbox"/> 1mg <input type="checkbox"/> 5mg <input type="checkbox"/> 10mg			
<input type="checkbox"/> sirolimus (Rapamune)	<b>Tabs:</b> <input type="checkbox"/> 0.5mg <input type="checkbox"/> 1mg <input type="checkbox"/> 2mg <b>Soln:</b> <input type="checkbox"/> 1mg/mL			
<input type="checkbox"/> tacrolimus (Prograf)	<b>Caps:</b> <input type="checkbox"/> 0.5mg <input type="checkbox"/> 1mg <input type="checkbox"/> 5mg			
<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:	

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# SOLID ORGAN TRANSPLANT REFERRAL FORM

(opportunistic infection prophylaxis and treatment)

## 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

- |                                                                                             |                                                                     |                                       |
|---------------------------------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------|
| <input type="checkbox"/> <b>B25.9</b> cytomegalovirus (CMV) prophylaxis and/or treatment    | <input type="checkbox"/> <b>Z94.0</b> kidney replaced by transplant | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> <b>B44.9</b> <i>Aspergillus</i> prophylaxis and/or treatment       | <input type="checkbox"/> <b>Z94.2</b> lung replaced by transplant   | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> <b>B59</b> Pneumocystis PNA (PCP/PJP) prophylaxis and/or treatment | <input type="checkbox"/> <b>Z94.3</b> heart replaced by transplant  | <input type="checkbox"/> Other: _____ |
|                                                                                             | <input type="checkbox"/> <b>Z94.4</b> liver replaced by transplant  | <input type="checkbox"/> Other: _____ |

Date of transplant:	Labs (please attach most recent results): <input type="checkbox"/> CMP <input type="checkbox"/> CMV level <input type="checkbox"/> C&S report(s)
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
<b>Prophylaxis and/or Treatment, <i>Aspergillus</i></b>				
<input type="checkbox"/> Cresemba	Caps: <input type="checkbox"/> 74.5mg <input type="checkbox"/> 186mg	<input type="checkbox"/> <b>Initiation:</b> 372mg PO Q8h x 6 doses <input type="checkbox"/> <b>Maintenance:</b> 372mg PO once daily		
<input type="checkbox"/> posaconazole	Susp: <input type="checkbox"/> 40mg/mL Tabs: <input type="checkbox"/> 100mg			
<input type="checkbox"/> voriconazole	Susp: <input type="checkbox"/> 40mg/mL Tabs: <input type="checkbox"/> 50mg <input type="checkbox"/> 200mg			
<b>Prophylaxis and/or Treatment, CMV</b>				
<input type="checkbox"/> Livtency	200mg tablet	400mg PO twice daily for _____ weeks		
<input type="checkbox"/> Prevymis	Tabs: <input type="checkbox"/> 240mg <input type="checkbox"/> 480mg	_____mg PO once daily for _____ weeks		
<input type="checkbox"/> valganciclovir	Tabs: <input type="checkbox"/> 500mg <input type="checkbox"/> 1g			
<input type="checkbox"/> valganciclovir (Valcyte)	Soln: <input type="checkbox"/> 50mg/mL Tabs: <input type="checkbox"/> 450mg			
<b>Prophylaxis and/or Treatment, PCP/PJP</b>				
<input type="checkbox"/> atovaquone	750mg/5mL suspension	10mL (1.5g) PO once daily		
<input type="checkbox"/> SMZ/TMP	Susp: <input type="checkbox"/> 200/40mg per 5mL Tabs: <input type="checkbox"/> 800/160mg <input type="checkbox"/> 400/80mg			
<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:	

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