White Blood Cell Stimulators (Leukine®, Neupogen®, Neulasta®)
Physician Request Form

Fax to Pharmacy Services at **855-811-9332**, or to speak to a Representative, call **888-602-3741**. ***Form must be completed for processing.***

Patient Name: ______________________________ Patient ID#: ____________________

Address: ______________________________ Apt # or Suite #: ____________________

City: ____________________ State: ____________________ Zip Code: ____________________

Phone #: ____________________ Birth Date: ____________________

Physician Name: ____________________ NPI #: ____________________

Address: ______________________________ Apt # or Suite #: ____________________

City: ____________________ State: ____________________ Zip Code: ____________________

Contact Person: ____________________ Phone #: ____________________ Fax #: ____________________

Physician Signature: ______________________________

❑ **Deliver to Patient's Home** ❑ **Deliver to Physician's Office** ❑ **Pick-up at Local Pharmacy (Name/Phone#):** ____________________

Diagnosis: ____________________ Absolute Neutrophil Count (ANC): ____________ c/mm³ Date of Test: ____________

*Formula: ANC=WBC **x** (polys + bands)/100* *Neutropenia = ANC< 1000 c/mm³ (Severe is < 500 c/mm³)*

To be Administered From: __________ to __________ OR Length of therapy: __________ OR on the following treatment dates: __________

Refills: ____________

❑ **NEUPOGEN REQUESTS** – Patient's Weight: ________ Kg OR ________ lbs AND Absolute Neutrophil Count (ANC): ________ c/mm³

Date of Test: ________

PLEASE CHECK THE PRESCRIPTION DOSE OF NEUPOGEN	
Flat Dosing Based on Actual Body Weight	
Prescription Dose Of Medication	Patient Body Weight
❑ 300 mcg vial daily	$\leq$ 75 kg
❑ 480 mcg vial daily	> 75 Kg
Indicate Exact Dose Calculated Based On Actual Body Weight BASED ON 5 MCG/KG/DAY or 10 MCG/KG/DAY	
❑ Daily Dose of Neupogen__________ mcg	

Other Prescription Dose (i.e. 6mcg/kg for congenital neutropenia): Dose: ________ mcg, Frequency: ____________________

❑ **LEUKINE REQUESTS** - Body Surface Area (BSA) __________ m² OR Height: ________ AND Weight: ________ lbs OR ________ kg

The recommended **starting dose** for the treatment of **chemotherapy-induced neutropenia** and most other indications is **250 mcg/m²/day**. Do not administer earlier than 24 hours after administration of last dose of cytotoxic chemotherapy. Leukine should be discontinued when ANC surpasses 1500 cells/mm³ for 3 consecutive days.

PLEASE CHECK THE PRESCRIPTION FOR LEUKINE BASED ON 250 MCG/M²/DAY			
Prescription Dose and Vial Dispensed for Calculated Body Surface Area	**Calculated Body Surface Area (m²)**	**Prescription Dose for calculated Body Surface Area)**	**Calculated Body Surface Area (m²)**
❑ 250 mcg daily (give 1ml of 250 mcg/ml vial)	1.0	❑ 400 mcg daily (give 0.8 ml of 500 mcg/ml MDV)	1.6
❑ 300 mcg daily (give 0.6 ml of 500 mcg/ml MDV)	1.2	❑ 450 mcg daily (give 0.9 ml of 500 mcg/ml MDV)	1.8
❑ 350 mcg daily (give 0.7 ml 500 mcg/ml MDV)	1.4	❑ 500 mcg daily (give 1.0 ml of 500 mcg/ml MDV)	2.0

ALTERNATIVE 250 MCG/M2/DAY FLAT DOSING FOR PATIENTS THAT WEIGH >40 KG, CHECK PRESCRIPTION ACCORDING TO PATIENT'S BSA	
Prescription Dose and Vial Dispensed for Calculated Body Surface Area	**Calculated Body Surface Area (m²)**
❑ 400 mcg daily (give 0.8 ml of 500 mcg/ml MDV)	$\leq$ 1.8 m²
❑ 500 mcg daily (give 1.0 ml of 500 mcg MDV)	> 1.8 m²

Other Prescription Dose (i.e. patient BSA <1 m²): Dose: ____________ mcg, Frequency: ____________________

❑ **NEULASTA REQUESTS** ❑ Ordered Dose of Neulasta: ________ mg: Sig: ______________________________

Absolute Neutrophil Count (ANC): ________ c/mm³ Date of Test: __________

If requesting **Neulasta**, please provide documentation of a reason (prior treatment failure, dose dense chemotherapy, etc) for why the patient is unable to take **Neupogen** to treat their medical condition:

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PerformRx