SEND TO BANKS APOTHECARY FAX (215) 357 2129

Physician Request Form for Patient Self-Administered Injectable and Specialty Drugs

Fax to Pharmacy Services at **888-981-5202**, or to speak to a representative call **866-610-2774**. *Form must be completed for processing.*

Patient Name: _____ Patient ID#: _____

Address: _____ Apt # or Suite #: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Height: _____ Weight: _____lbs = _____Kg Birth Date: _____

Physician Name: _____ NPI #: _____

Address: _____ Apt # or Suite #: _____

City: _____ State: _____ Zip Code: _____

Contact Person: _____ Phone #: _____ Fax #: _____

To be Administered from: _____ to _____ or on:_____

Drug Name: _____ Item # (see below): _____

Sig (How Administered): _____

Diagnosis: _____ ICD-9 Diagnosis Code: _____

Justification for Drug Use (Add Attachment if Necessary):_____

_____

_____

_____

Deliver to:

☐ Patient's Home ☐ Physician's Office ☐ Patient Filling at Local Pharmacy (Name): BANK'S APOTHECARY Phone: 215 494 9403

Physician Signature: _____ Date: _____

Anticoagulants			Preferred NDCs	GCNs
Heparin Sodium Does Not require prior Authorization				
#1 Heparin Sodium				
Dose:		Sig:		
#2 Fragmin	2,500U/0.2mL	syringe, 10s	62856-0250-10	63488
#3 Fragmin	5,000U/0.2mL	syringe, 10s	62856-0500-10	63431
#4 Fragmin	7,500U/0.3mL	syringe, 10s	62856-0750-10	94116
#5 Fragmin	10,000U/1mL	syringe, 10s	62856-0101-10	95075
#6 Fragmin	2,500U/mL	vial, 3.8mL	62856-0251-01	95776
#7 Fragmin	10,000U/mL	vial, 9.5mL	62856-0102-01	63731
#8 Lovenox	30mg/0.3mL	syringe, 10s	00075-0624-30	00420
#9 Lovenox	40mg/0.4mL	syringe, 10s	00075-0620-40	70022
#10 Lovenox	60mg/0.6mL	syringe, 10s	00075-0621-60	62771
#11 Lovenox	80mg/0.8mL	syringe, 10s	00075-0622-80	62772
#12 Lovenox	100mg/1mL	syringe, 10s	00075-0623-00	62773
#13 Lovenox	120mg/0.8mL	syringe, 10s	00075-2912-01	42091
#14 Lovenox	150mg/1mL	syringe, 10s	00075-2915-01	42071
#15 Lovenox	100mg/1mL	vial, 3.0mL	00075-0626-03	96334
#16 Arixtra	2.5mg/0.5ml	syringe, 10s	00007-3230-02	15494
#17 Arixtra	5mg/0.4ml	syringe, 10s	00007-3232-02	23775
#18 Arixtra	7.5mg/0.6ml	syringe, 10s	00007-3234-11	23776
#17 Arixtra	10mg/0.8ml	syringe, 10s	00007-3236-11	23777
Hormones				
#16 Depo-Testosterone	100 mg/mL	10 mL vial, 1s	00009-0347-02	10191
#17 Depo-Testosterone	200 mg/mL	10 mL vial , 1s	00009-0417-02	10194
#18 Depo-Estradiol	5 mg/mL	5 mL vial, 1s	00009-0271-01	10660

Pulmonary Drugs				
#23 Pulmozyme	1 mg/mL	2.5mL Neb-Ampul 30s	50242-0100-40	27200
#24 Tobi	300mg/5mL	5mL Neb-Ampul, 1s	63430-0065-01	61551
Multiple Sclerosis Treatments				
Indicate Type of MS				
❑ **Relapsing Remitting**				
❑ **Secondary Progressive with Relapses**				
❑ **Primary Progressive**				
#25 Copaxone	20 mg/2mL,	2 mL vial, kit, 32s	00088-1150-03	16431
#26 Avonex	30 mcg	0.5 syringe	59627-0002-05	20147
#27 Avonex Admin Pack	30 mcg	0.5 syringe	59627-0002-05	17486
Miscellaneous				
Cyanocobalamin DOES NOT require prior authorization				
#28 Cyanocobalamin	1000mcg/mL,10mL vial,	1s	00517-0032-25	94594
#29 Other (write in):				

- Avonex, Copaxone, Hormones, and Pulmozyme: initial 30 days supply & 5 refills allowed. All other medications must be requested monthly.

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