NEPHROLOGY REFERRAL FORM

PATIENT INFORMATION

Last Name _____ First Name _____

Social Security No _____ Date of Birth _____

Sex □ M □ F Weight_____ Height_____ Allergies_____

Home Phone _____ Work/Mobile _____

Home Address _____

City _____ State _____ Zip _____

PATIENT INSURANCE INFORMATION

Primary Medical Insurance _____ Medical Insurance Phone _____

Subscriber Name _____

Rx Card (PBM) _____ Group No _____

Prescription Card Bin # _____ PCN # _____

TREATMENT ARRANGEMENTS

•Start Date:_____ Ship Meds □ Home □ Doctor's Office

Teaching by: □ Doctor's Office □ Other:_____

DIAGNOSIS & STATEMENT OF MEDICAL NECESSITY

Diagnosis: □ Anemia due to Chronic Renal Failure on Dialysis □ Anemia due to Chronic Renal Failure Not on Dialysis □ Neutropenia (D70.1)
□ Other_____

MEDICAL ASSESSMENT :(Please provide the information below or Fax copies of labs to Fax number provided above.)

Prior and During Therapy Iron Store Evaluation Needed:

1. Is Transferrin Saturation at least 20%? □ Yes □ No _____% Date:___/___/___
2. Is Ferritin at least 100ng/ml? □ Yes □ No _____ng/ml Date:___/___/___
3. Is Blood Pressure adequately controlled and would it be closely monitored and controlled during therapy ? □ Yes □ No , BP_____
4. Hgb _____ Hct _____ Serum Fe _____

Has Patient been treated previously for this condition ? □ Yes □ No
Medication(s) failed: □ Iron □ Folic Acid □ Vitamin B12 □ Procrit □ Epogen □ Other _____

Is patient Currently on therapy ?: □ Yes □ No Medication(s) _____

Will patient stop taking the above medication(s) before starting the new medication ?: □ Yes □ No ; if yes, what is the wash out period ?

Other medication(s) patient is currently taking including OTC medications with dosage and direction (or fax medication profile);

PRESCRIPTION INFORMATION

□ **Procrit** □ **Epogen** (In patients on hemodialysis,IV route is recommended)

□ 2000 units/ml □ 3000 units/ml □ 4000 units/ml □ 10,000 units/ml □ 20,000 units/ml □ 40,000 units/ml
□ SQ □ SQ □ SQ every week □ Other _____
□ IV Bolus □ IV Bolus □ IV Bolus every week □ Other _____
Qty:_____ Refills:_____

□ **Aranesp** (comes in: SureClick Autoinjector, PFS"pre-filled syringes", vial)

□ 25 mcg/0.42 ml (SureClick Autoinjector)	□ 25 mcg/0.42 ml (PFS)	□ 25 mcg/ml (Vial)
□ 40 mcg/0.4 ml (SureClick Autoinjector)	□ 40 mcg/0.4 ml (PFS)	□ 40 mcg/ml (Vial)
□ 60 mcg/0.3 ml (SureClick Autoinjector)	□ 60 mcg/0.3 ml (PFS)	□ 60 mcg/ml (Vial)
□ 100 mcg/0.5 ml (SureClick Autoinjector)	□ 100 mcg/0.5 ml (PFS)	□ 100 mcg/ml (Vial)
□ 150 mcg/0.3 ml (SureClick Autoinjector)	□ 150 mcg/0.3 ml (PFS)	□ 150 mcg/0.75 ml (Vial)
□ 200 mcg/0.4 ml (SureClick Autoinjector)	□ 200 mcg/0.4 ml (PFS)	□ 200 mcg/ml (Vial)
□ 300 mcg/0.6 ml (SureClick Autoinjector)	□ 300 mcg/0.6 ml (PFS)	□ 300 mcg/ml (Vial)
□ 500 mcg/ml (SureClick Autoinjector)	□ 500 mcg/ml (PFS)	□ 500 mcg/ml (Vial)

□ SQ every week □ SQ every Other week (□ IV every week □ IV Every other week) □ Other_____ Qty:_____Refills:_____

□ **Neupogen** □ Daily * _____ days □ very week □ BIW □ TIW
□ 300 mcg SQ □ 480 mcg SQ □ Other_____ Qty:_____ Refills:_____

□ **Other**_____ Qty:_____ Refills:_____

Physician Signature: _____ □ **DAW (Dispense as Written)** **Date:** _____

Physician Name: _____ **Phone:** _____ **Fax:** _____ **Office Contact:** _____

Physician Address: _____ **NPI:** _____ **DEA:** _____

FAX TO 747-900-8489

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