

NEPHROLOGY REFERRAL FORM

PATIENT INFORMATION

Patient Name:		DOB:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Weight:	<input type="checkbox"/> lbs. <input type="checkbox"/> kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	<input type="checkbox"/> Please attach demographic information		

PRESCRIBER INFORMATION

Prescriber:		NPI:	DEA:	State Lic:	
Supervising Physician:		Practice Name:			
Address:		City:	State:	Zip:	
Phone:	Fax:	Key Office Contact:		Phone:	

DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT

Primary Diagnosis: Anemia due to Chronic Renal Failure on Dialysis Anemia due to Chronic Renal Failure NOT on Dialysis Neutropenia (288.03)
 Other: _____

Medical Assessment: Please provide the information below or fax copies to the number above.

- Prior and during therapy iron store evaluation needed:
1. If Transferrin Saturation at least 20%? Yes No _____ % Date: _____
 2. If Ferritin at least 100 ng/mL? Yes No _____ % Date: _____
 3. Is blood pressure adequately controlled and would it be closely monitored and controlled during therapy? Yes No, BP _____ Date: _____
 4. Hbg: _____ Hct: _____ Serum Fe: _____ Date: _____
- Has patient been treated *previously* for this condition? Yes No Medication(s): _____
 - 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: _____
 - Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile): _____
 - Does the patient have any of the following conditions: uncontrolled hypertension, pure red cell aplasia (PRCA) that begins after treatment with Procrit or other erythropoietin protein drugs, serious allergic reactions to the drug of choice? Yes No

INSURANCE INFORMATION

Please attach front and back of patient's insurance card (medical and prescription)

COPAY CARD ENROLLMENT

Please check if enrolling in copay card Copay ID: _____

PRESCRIPTION INFORMATION

<input type="checkbox"/> Procrit (OR) Epogen <i>*In patients with hemodialysis, IV route if recommended</i>			
<input type="checkbox"/> 2000 units/mL <input type="checkbox"/> 3000 units/mL <input type="checkbox"/> 4000 units/mL <input type="checkbox"/> 10,000 units/mL <input type="checkbox"/> 20,000 units/mL MDV* <input type="checkbox"/> 20,000 units/2mL MDV* <input type="checkbox"/> 40,000 units/mL		QTY: _____	Refills: _____
<input type="checkbox"/> SQ twice weekly <input type="checkbox"/> SQ three times weekly <input type="checkbox"/> SQ every week <input type="checkbox"/> IV bolus twice weekly <input type="checkbox"/> IV bolus three times weekly <input type="checkbox"/> IV bolus every week			
<input type="checkbox"/> Other _____		QTY: _____	Refills: _____
<input type="checkbox"/> Aranesp 100 mcg/0.5 mL Prefilled Syringe			
<input type="checkbox"/> 10 mcg/0.4 mL <input type="checkbox"/> 25 mcg/0.42 mL <input type="checkbox"/> 40 mcg/0.4 mL <input type="checkbox"/> 60 mcg/0.3 mL <input type="checkbox"/> 150 mcg/0.3 mL <input type="checkbox"/> 200 mcg/0.4 mL <input type="checkbox"/> 300 mcg/0.6 mL		QTY: _____	Refills: _____
<input type="checkbox"/> 500 mcg/mL			
<input type="checkbox"/> SQ every week <input type="checkbox"/> SQ every other week (<input type="checkbox"/> IV every week <input type="checkbox"/> IV every other week)			
<input type="checkbox"/> Aranesp 150 mcg/0.75 mL Vial			
<input type="checkbox"/> 25 mcg/mL <input type="checkbox"/> 40 mcg/mL <input type="checkbox"/> 60 mcg/mL <input type="checkbox"/> 100 mcg/mL <input type="checkbox"/> 200 mcg/mL <input type="checkbox"/> 300 mcg/mL <input type="checkbox"/> 500 mcg/mL		QTY: _____	Refills: _____
<input type="checkbox"/> SQ every week <input type="checkbox"/> SQ every other week (<input type="checkbox"/> IV every week <input type="checkbox"/> IV every other week)			
<input type="checkbox"/> Neupogen Prefilled Syringe			
<input type="checkbox"/> 300 mcg/0.5mL <input type="checkbox"/> 480 mcg/0.8 mL		QTY: _____	Refills: _____
<input type="checkbox"/> Daily _____ days <input type="checkbox"/> every week <input type="checkbox"/> twice weekly <input type="checkbox"/> three times weekly			
<input type="checkbox"/> Neupogen Vial			
<input type="checkbox"/> 300 mcg/mL <input type="checkbox"/> 480 mcg/1.6 mL		QTY: _____	Refills: _____
<input type="checkbox"/> Daily _____ days <input type="checkbox"/> every week <input type="checkbox"/> twice weekly <input type="checkbox"/> three times weekly			
<input type="checkbox"/> Other: _____		QTY: _____	Refills: _____

Prescriber's Signature: _____ DAW (Dispense as Written) **Date:** _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send prescription on official state prescription blank. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.

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