Date Shipment Needed: _____ Ship To: ❑Patient ❑Prescriber
❑ Nursing needed; ❑Training needed ► All the supplies including syringes and needles will be dispensed if needed.

NEPHROLOGY REFERRAL FORM

PATIENT INFORMATION

Patient Name:		DOB:	Sex: ❑M ❑F	Weight:	❑lbs. ❑kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	❑ **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 ASSESMENT

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

❑**Procrit** (**OR**) ❑**Epogen** **In patients with hemodialysis, IV route if recommended*
❑2000 units/mL ❑3000 units/mL ❑ 4000 units/mL ❑10,000 units/mL ❑20,000 units/mL MDV* ❑20,000 units/2mL MDV* ❑40,000 units/mL QTY: _____ Refills:_____

❑SQ twice weekly ❑SQ three times weekly ❑SQ every week ❑IV bolus twice weekly ❑IV bolus three times weekly ❑IV bolus every week
❑Other_____ QTY: _____ Refills:_____

❑**Aranesp 100 mcg/0.5 mL Prefilled Syringe**
❑10 mcg/0.4 mL ❑25 mcg/0.42 mL ❑40 mcg/0.4 mL ❑60 mcg/0.3 mL ❑150 mcg/0.3 mL ❑200 mcg/0.4 mL ❑300 mcg/0.6 mL ❑500 mcg/mL QTY: _____ Refills:_____

❑SQ every week ❑SQ every other week (❑IV every week ❑IV every other week)

❑**Aranesp 150 mcg/0.75 mL Vial**
❑25 mcg/mL ❑40 mcg/mL ❑60 mcg/mL ❑100 mcg/mL ❑200 mcg/mL ❑300 mcg/mL ❑500 mcg/mL QTY: _____ Refills:_____

❑SQ every week ❑SQ every other week (❑IV every week ❑IV every other week)

❑**Neupogen Prefilled Syringe**
❑300 mcg/0.5mL ❑480 mcg/0.8 mL QTY: _____ Refills:_____

❑Daily _____ days ❑every week ❑twice weekly ❑three times weekly

❑**Neupogen Vial**
❑300 mcg/mL ❑480 mcg/1.6 mL QTY: _____ Refills:_____

❑Daily _____ days ❑every week ❑twice weekly ❑three times weekly

❑**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 the receiving pharmacy, this prescription shall be forwarded to an eligible pharmacy.

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