RE PHARMACY
PASSION FOR LIFE

866 413-3156 toll free phone
877 834-1231 toll free fax
QUESTIONS? Please contact us!
www.REPharmacy.com

Hematopoietic Prescription Referral Form

Send your Rx to:

Date Medication Needed: _____ Ship To: (○) Patient's Home (○) Prescriber's Office (○) Pick-up (store location): _____ Injection training by pharmacy? ☐

1. Patient Information | Insurance Information

Please include copies of the FRONT and BACK of ALL insurance cards (prescription and medical) with this fax.

Patient Name: _____ Birthdate: _____ Sex: (○) Male (○) Female Height: _____ Weight: _____ ( ) lbs. ( ) kg.
Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____
Address: _____ City: _____ State: _____ Zip: _____
Alternate Caregiver Name: _____ Preferred Phone: _____

2. Prescriber Information

Provider Name: _____ Specialty: _____ DEA#: _____ NPI#: _____ Tax ID#: _____
Address: _____ Phone: _____ Fax: _____
City, State, Zip: _____ Key Contact: _____ Phone: _____

3. Diagnosis/Clinical Information

Please FAX recent clinical notes, labs, tests, with the prescription to expedite the prior authorization.

Body Weight: _____ lb/Kg Age: _____ Adult/Pediatric: _____

Diagnosis:

☐ Anemia due to CKD
☐ Anemia due to myelosuppressive chemotherapy
☐ Anemia due to Zidovudine Therapy in HIV Patients
☐ Elective Surgery
☐ Dialysis/No Dialysis
☐ Type of Cancer: _____ Length of Therapy: _____
☐ Serum Erythropoietin Level: _____<mUnits/ml
☐ Type of Surgery: _____ Date: _____

Lab Work:

☐ SCr.: _____
☐ Crcl: _____
☐ Hg Level _____ g/dl Date: _____
☐ Hematocrit: _____ %
☐ Platelets Count: _____
☐ Serum Ferritin (Iron Stores): _____ mcg/L
☐ TSAT Transferrin Saturation: _____ %

History / Current Medical Status:

☐ Uncontrolled BP - BP record: _____
☐ Seizures disorder - Specify: _____
☐ Pregnant / Nursing: _____
☐ Heart disease - Specify: _____
☐ Stroke / DVT / PT: _____
☐ Bleeding Disorder - Specify: _____
☐ Any Allergy - Specify: _____
☐ Patient been previously on any ESA Therapy? (○) Yes (○) No
Drug Name: _____ For how long?: _____

4. Prescription Information

Drug Name	Strenght	Dose / Frequency / Route	Refill
Procrit (Epoetin Alfa)	☐ 2,000 u/ml SDV ☐ 10,000 u/ml SDV ☐ 40,000 u/ml ☐ 3,000 u/ml SDV ☐ 20,000 u/ml MDV ☐ 4,000 u/ml SDV ☐ 20,000 u/2ml (10,000 / 1ml) MDV	Inject _____ u/kg OR _____ Units ☐Once per week ☐Twice per week ☐Three times per week Other: _____ IV / SC	
Epogen (Epoetin Alfa)	☐ 2,000 u/ml SDV ☐ 10,000 u/ml SDV ☐ 3,000 u/ml SDV ☐ 20,000 u/ml MDV ☐ 4,000 u/ml SDV ☐ 20,000 u/2ml (10,000 / 1ml) MDV	Inject _____ u/kg OR _____ Units ☐Once per week ☐Twice per week ☐Three times per week Other: _____ IV / SC	
Aransep (Darbepoetin Alfa)	**Single Dose Vials:** ☐150mcg/0.75ml ☐25 ☐40 ☐60 ☐100 ☐200 ☐300 ☐500 mcg/ml **Single Dose Prefilled Syringes:** ☐10mcg/0.4ml ☐25mcg/0.42ml ☐40mcg/0.4ml ☐60mcg/0.3ml ☐100mcg/0.5ml ☐150mcg/0.3ml ☐200mcg/0.4ml ☐300mcg/0.6ml ☐500mcg/ml	Inject _____mcg/kg OR _____mcg ☐Once every week ☐Once every 2 weeks ☐Once every 3 weeks Other: _____ IV / SC	

5. Patient Support Programs

Please sign and date below to enroll in the pharmaceutical company assisted patient support program.

Patient Signature **Date**

6. Prescriber Signature

Prescriber, please sign and date below

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to RE Pharmacy to act as the prescriber's agent to begin and execute prior authorization process and to help patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Dispense as written **Date** **Substitution Permissible** **Date**

# of Prescriptions: _____

Faxed prescriptions will only be accepted from a prescribing practitioner. Prescribers are reminded patients may choose any pharmacy of their choice.