Anemia

PRESCRIPTION & ENROLLMENT FORM

☐ New patient
☐ Current

1 PATIENT INFORMATION

Patient name _____

Date of birth _____ ☐ Male ☐ Female Last 4 digits of SSN _____

Street address _____

City _____ State _____ Zip _____

Parent/guardian (if applicable) _____

Home phone _____ Work phone _____

Cell phone _____ Evening phone _____

E-mail address _____

Insurance company name _____

Phone# _____

Insured name _____

Relationship to patient _____

Identification # _____ Policy/group # _____

Prescription card ☐ No ☐ Yes If yes, carrier _____

Policy # _____ Group # _____

Is patient eligible for Medicare? ❑ No ❑ Yes Please attach copies of patient's insurance cards, if available.

2 PRESCRIBER INFORMATION

Prescriber name _____

Office contact _____

Clinic/hospital affiliation _____

Street address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

E-mail address _____

NPI # _____ License # _____

DEA # _____

Physician Medicaid UPIN # _____

MD specialty _____ _____

Fax Referral To 718-360-9655 Or Call 718-556-0942

Enexia Specialty

3 CLINICAL INFORMATION

Primary ICD- 10 code _____

Current weight_____ kg/lbs Date recorded

Laboratory results: Hematocrit_____% Hemaglobin_____g/dl Platelets_____

Date _____ Date _____ Date _____

EXPECTED DATE OF FIRST/NEXT INJECTION _____ DATE OF LAST INJECTION (if applicable) _____

Agency nurse to visit home for injection: ❑ Yes ❑ No

Agency name & phone _____

4 PRESCRIBING INFORMATION

❑ Aranesp® (darpopoetin alfa)

❑ Epogen® (epoetin alfa)

❑ Procrit® (epoetin alfa)

SIG: Inject dose _____ mcg/kg or _____mcg

Route: ❑ IV ❑ SC Frequency _____

Dispense quantity _____ Refills _____

Supplies (if needed per dose): ❑ 1mL syringe ❑ 3 mL syringe

❑ 7G 5/8" needle ❑ 25G 5/8" needle ❑ 271/ 2G 5/8" pediatrics only

❑ NKDA ❑ Known drug aller gies _____

Deliver product to: ❑ Office ❑ Patient home ❑ Clinic/clinic location

_____

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

By signing below, I certify that the above therapy is medically necessary.

Prescriber printed name _____

Prescriber signature (sign below) Date _____

_____ _____

Dispense as written Substitution allowed

(Physician attests this is his/her legal signature. NO STAMPS)

This prescription is valid only if transmitted by means of a facsimile machine.