

## Patient Information

(Please attach insurance card)

Name:		<input type="checkbox"/> M	<input type="checkbox"/> F	DOB: _____/_____/_____	
Street:		City:		State:	Zip:
Phone:	Alt Phone:		Allergies:		

## Clinical Information

(Please attach all pertinent clinicals and lab results)

**Diagnosis:** \_\_\_\_\_ **ICD 10:** \_\_\_\_\_ **Hgb:** \_\_\_\_\_

**Clinical History:** **Hct:** \_\_\_\_\_

Is Transferrin Saturation at least 20%?  yes  No \_\_\_\_\_ %

Is Ferritin at least 100ng/mL?  yes  No \_\_\_\_\_ ng/mL

Is Patient on dialysis?  yes  No

Phosphorus Level: \_\_\_\_\_ **Serum Fe:** \_\_\_\_\_

**Previous/current treatment history:** \_\_\_\_\_ **Treatment Dates:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Prescription

(Or e-scribe to Synergen Rx - NPI: 1811550528)

Drug Therapy	Dosing	Directions	Quantity	Refills
<input type="checkbox"/> Aranesp PFS	<input type="checkbox"/> 40mcg/0.4ml <input type="checkbox"/> 25mcg/0.42ml <input type="checkbox"/> 100mcg/0.5ml <input type="checkbox"/> 60mcg/0.3ml <input type="checkbox"/> 200mcg/0.4ml <input type="checkbox"/> 150mcg/0.3ml <input type="checkbox"/> 500mcg/ml <input type="checkbox"/> 300mcg/0.6ml			
<input type="checkbox"/> Auryxia	<input type="checkbox"/> 1 gm (210 mg Ferric Iron)			
<input type="checkbox"/> Cuprimine (penicillamine)	<input type="checkbox"/> 250 mg capsules			
<input type="checkbox"/> Fosrenol	<input type="checkbox"/> 500mg tablets <input type="checkbox"/> 750mg tablets <input type="checkbox"/> 1,000mg tablets			
<input type="checkbox"/> Injectafer	<input type="checkbox"/> 750 mg			
<input type="checkbox"/> Renagel	<input type="checkbox"/> 400 mg tablets <input type="checkbox"/> 800 mg tablets			
<input type="checkbox"/> Renvela	<input type="checkbox"/> 800 mg tablets <input type="checkbox"/> 2.4g powder for suspension <input type="checkbox"/> 0.8g powder for suspension			
<input type="checkbox"/> Retacrit (Biosimilar for Procrit & Epogen)	<input type="checkbox"/> 2000 u/ml <input type="checkbox"/> 3000 u/ml <input type="checkbox"/> 10,000 u/ml <input type="checkbox"/> 20,000 u/ml <input type="checkbox"/> 40,000 u/ml <input type="checkbox"/> 20,000 u/2ml			
<input type="checkbox"/> Sensipar	<input type="checkbox"/> 30 mg <input type="checkbox"/> 60 mg <input type="checkbox"/> 90 mg			
<input type="checkbox"/> Veltassa	<input type="checkbox"/> 8.4 gm			
<input type="checkbox"/> Venofer	<input type="checkbox"/> 20 mg / mL			

## Prescriber information

Deliver To:  Patient  Office

Prescriber:		Supervising Physician:			
Contact Name:			Preferred method of contact: <input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Email		
Phone:	Ext:	Fax:	Email:		
Street:		City:		State:	Zip:
Signature:		Date:		NPI	