



PATIENT INFORMATION (Complete or Fax Existing Chart)		PRESCRIBER INFORMATION	
Name: _____ DOB: _____ Address: _____ City, State, Zip: _____ Phone: _____ Alt. Phone: _____ Email: _____ SS#: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____ Allergies: _____		Prescriber Name: _____ State License: _____ NPI #: _____ DEA: _____ Address: _____ City, State, Zip: _____ Phone: _____ Fax: _____ Office Contact: _____ Phone: _____	
INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)			
Primary Insurance: _____ Plan #: _____ Group #: _____ RX Card (PBM): _____ BIN: _____ PCN: _____		Secondary Insurance (If Applicable): _____ Plan #: _____ Group #: _____ RX Card (PBM): _____ BIN: _____ PCN: _____	
CLINICAL INFORMATION			
Primary ICD-10 (Please Specify Diagnosis): _____		Secondary ICD-10 (Please Specify Diagnosis): _____	
Tertiary ICD-10 (Please Specify Diagnosis): _____			
Is the patient on iron, folate and/or vitamin B12 therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No      Is the patient on dialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Has patient received any ESA therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No      If yes, how many weeks of ESA therapy has the patient completed? _____ weeks			
Patient's hemoglobin (Hgb) level: _____ g/dL			
** Obtain the following labs at prior to start of treatment and at _____ frequency: <input type="checkbox"/> CBC <input type="checkbox"/> CMP <input type="checkbox"/> CRP <input type="checkbox"/> ESR <input type="checkbox"/> LFTs <input type="checkbox"/> X-Ray <input type="checkbox"/> Other: _____			
ARANESP® ORDERS			
Prescription type: <input type="checkbox"/> New start <input type="checkbox"/> Restart <input type="checkbox"/> Continued therapy      Total Doses Received: _____      Date of Last Injection/Infusion: _____			
Medication	Dose	Frequency	Refills
<input type="checkbox"/> Aranesp® (darbepoetin alfa) Single Dose Vials <input type="checkbox"/> Aranesp® (darbepoetin alfa) Single Dose Prefilled Syringe	<input type="checkbox"/> 25 mcg <input type="checkbox"/> 40 mcg <input type="checkbox"/> 60 mcg <input type="checkbox"/> 100 mcg <input type="checkbox"/> 150 mcg <input type="checkbox"/> 200 mcg <input type="checkbox"/> 300 mcg    Other: _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Other: _____	Refills: _____
Special Instructions: _____			
Pre- Medication	Route	Dose	
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> PO	<input type="checkbox"/> 500mg <input type="checkbox"/> 650mg <input type="checkbox"/> 1000mg	
<input type="checkbox"/> Methylprednisolone (Solu-Medrol)	<input type="checkbox"/> IV	<input type="checkbox"/> 60mg <input type="checkbox"/> 100 mg <input type="checkbox"/> _____mg	
<input type="checkbox"/> Diphenhydramine (Benadryl)	<input type="checkbox"/> IV <input type="checkbox"/> PO	<input type="checkbox"/> 25mg <input type="checkbox"/> 50mg	
Other: _____		_____	
ANAPHYLACTIC REACTION (AR):			
<input type="checkbox"/> EpiPen® Auto-injector 0.3 mg (1:1000) Inject IM -or- SubQ to patients who weigh ≥ 66 lbs (≥ 30 kg); may repeat in 3-5 mins x 1 if necessary <input type="checkbox"/> EpiPen Jr® Auto-injector 0.15mg (1:2000) Inject IM -or- SubQ to patients who weigh 33 - 66 lbs (15-30 kg); may repeat in 3-5 mins x 1 if necessary <input type="checkbox"/> Diphenhydramine 50mg (1mL) - Administer 50 mg VIA slow IVP, administer IM if no IV access; may repeat x 1 after 10 mins, if necessary <input type="checkbox"/> Methylprednisolone 40mg - administer 40 mg IVP -or- IM if no IV access <input type="checkbox"/> Sodium Chloride 0.9% 500 mL infuse IV at a rate of up to 999 mL/hr			

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**ARANESP®**

**Please Fax Completed Form To: 888-898-9113**

**Please Send a Copy of The Patient's Insurance Cards (Front & Back)**

☐ Other: \_\_\_\_\_

**SIGNATURE**

We hereby authorize Valustar to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X \_\_\_\_\_

Prescriber Signature

Date: \_\_\_\_\_

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

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