

Hematopoietics Referral Form

TODAY'S DATE:
DATE SHIPMENT NEEDED:
<input type="checkbox"/> NEW START <input type="checkbox"/> CONTINUATION OF THERAPY
SHIP TO: <input type="checkbox"/> PATIENT <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> KERR DRUG STORE: _____

GENERAL INFORMATION

PATIENT (FIRST NAME, LAST NAME):		ADDRESS:	
CITY:	STATE:	ZIP:	DOB:
SS#:	HOME#:	CELL#:	WORK#:
ALLERGIES:	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	HEIGHT:	WEIGHT:
CURRENT MEDS:			
PHYSICIAN NAME:		PRACTICE NAME/HOSPITAL:	
ADDRESS:	CITY:	STATE:	ZIP:
PHONE#:	FAX#:	STATE LIC#:	DEA#:
NURSE/KEY OFFICE CONTACT:		NPI#:	

INSURANCE INFORMATION

PRIMARY INSURANCE:		EMPLOYER:	
CARDHOLDER NAME:	ID#:	GROUP#:	PHONE#:
SECONDARY INSURANCE:	ID#:	GROUP#:	PHONE#:

STATEMENT OF MEDICAL NECESSITY

DIAGNOSIS:	DATE:		
LAB DATA (as applicable):	DATE DRAWN: _____		
<input type="checkbox"/> Hgb: _____	<input type="checkbox"/> Hct: _____	<input type="checkbox"/> Serum creatinine: _____ mg/dL	<input type="checkbox"/> GFR: _____ mL/min
<input type="checkbox"/> TIBC: _____	<input type="checkbox"/> Serum Fe: _____	<input type="checkbox"/> % Fe Sat: _____	<input type="checkbox"/> Ferritin: _____
<input type="checkbox"/> WBC: _____	<input type="checkbox"/> ANC: _____	<input type="checkbox"/> Platelets: _____	

PRESCRIPTION INFORMATION

MEDICATION	VIAL/SYRINGE SIZE	UNITS/DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Aranesp®	<input type="checkbox"/> 25 mcg <input type="checkbox"/> 100 mcg <input type="checkbox"/> 300 mcg <input type="checkbox"/> 40 mcg <input type="checkbox"/> 150 mcg <input type="checkbox"/> 500 mcg <input type="checkbox"/> 60 mcg <input type="checkbox"/> 200 mcg ----- <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Vial			
<input type="checkbox"/> Epogen®	<input type="checkbox"/> 2,000 unt/mL (SDV) <input type="checkbox"/> 10,000 unt/mL <input type="checkbox"/> 3,000 unt/mL (SDV) 2 mL vial (MDV) <input type="checkbox"/> 4,000 unt/mL (SDV) <input type="checkbox"/> 20,000 unt/mL <input type="checkbox"/> 10,000 unt/mL (SDV) 1 mL vial (MDV)			
<input type="checkbox"/> Leukine®	<input type="checkbox"/> 250 mcg vial (lyophilized) <input type="checkbox"/> 500 mcg vial (liquid)			
<input type="checkbox"/> Neulasta®	6 mg prefilled syringe			
<input type="checkbox"/> Neumega®	5 mg vial kit			
<input type="checkbox"/> Neupogen®	<input type="checkbox"/> 300 mcg <input type="checkbox"/> 480 mcg ----- <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Vial			
<input type="checkbox"/> Procrit®	<input type="checkbox"/> 2,000 unt/mL (SDV) <input type="checkbox"/> 10,000 unt/mL <input type="checkbox"/> 3,000 unt/mL (SDV) 2 mL vial (MDV) <input type="checkbox"/> 4,000 unt/mL (SDV) <input type="checkbox"/> 20,000 unt/mL <input type="checkbox"/> 10,000 unt/mL (SDV) 1 mL vial (MDV) <input type="checkbox"/> 40,000 unt/mL (SDV)			
SUPPLEMENTS (Prescription or OTC)	Product:			

I authorize Kerr Health Specialty Pharmacy and its representatives to act as my agent for prior authorization and prescription processing for this patient.

Physician Signature: _____ Date: _____

Important Notice: This transmission may contain confidential health information that is legally protected. As you are obligated to maintain it in a safe and confidential manner, unauthorized re-disclosure or a failure to maintain the confidentiality of the information contained herein could subject you to penalties under state and federal law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination or copying of this communication is strictly prohibited.