Nephrology Enrollment Form

Fax: 909-284-9140
Phone: 909-266-0016
□ **Urgent Request**
Rep:

PATIENT INFORMATION

Patient Name_____
Address_____
Address 2 _____
City, State, Zip _____
Home Phone_____Mobile Phone _____
DOB_____ Gender__

PRESCRIBER INFORMATION

Prescriber Name _____
DEA_____
NPI _____
Address_____
City, State, Zip_____
Phone_____Fax_____
Contact Person _____

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
☐ **Epogen** ☐ **Procrit**	☐ **2,000 units/ml** ☐ **3,000 units/ml** ☐ **4,000 units/ml** ☐ **10,000 units/ml** ☐ **20,000 units/ml MDV** ☐ **20,000 units/2ml MDV** ☐ **40,000 units/ml**	☐ **SQ Every Week** ☐ **SQ Twice Weekly** ☐ **SQ Three Times Weekly** ☐ _____		
☐ **Aranesp**	☐ **25mcg SDV** ☐ **40mcg SDV** ☐ **60mcg SDV** ☐ **100 mcg SDV** ☐ **200mcg SDV** ☐ **300 mcg SDV** ☐ **10mcg/0.4ml PFS** ☐ **25mcg/0.42ml PFS** ☐ **40mcg/0.4ml PFS** ☐ **60mcg/0.3ml PFS** ☐ **100mcg/0.5ml PFS** ☐ **150mcg/0.3ml PFS** ☐ **200mcg/0.4ml PFS** ☐ **300mcg/0.6ml PFS** ☐ **500mcg/1ml PFS**	☐ **SQ Every Week** ☐ **SQ Every Other Week** ☐ **IV Every Week** ☐ **IV Every Other Week** ☐ _____		
☐ **Retacrit**	☐ **2,000 units/ml** ☐ **3,000 units/ml** ☐ **4,000 units/ml** ☐ **10,000 units.ml** ☐ **40,000 units/ml**			
☐ **Granix** ☐ **Neupogen**	☐ **300 mcg/0.5ml PFS** ☐ **480 mcg/0.8ml PFS** ☐ **300 mcg/ml vial** ☐ **480 mcg/1.6ml vial**	☐ **Daily x_____Days. Repeat Every _____Days.** ☐ _____		
☐ **Veltassa**	☐ **8.4 gm** ☐ **16.8 gm** ☐ **25.2 gm**	☐ **8.4 grams PO QD with food.** ☐		
☐ **Rayaldee**	☐ **30 mcg**	☐ **30 mcg PO QD HS** ☐ _____		
☐ **Auryxia**	☐ **1 g (210 mg Ferric Iron)**	☐ **2 Tabs PO TID With Food.** ☐ _____		
☐ **Benlysta**	☐ **200 mg/ml single-dose prefilled autoinjector** ☐ **200 mg/ml single-dose prefilled syringe**	☐ **400mg sq once weekly for 4 doses then, 200mg sq once weekly** ☐ **200mg sq once weekly**		
☐ **Krystexxa**	☐ **8 mg/vial**	☐ **8 mg given as an intravenous infusion every 2 weeks**		
☐ **Renagel** ☐ **Renvela**	☐ **400 mg tab** ☐ **800 mg tab** ☐ **0.8 gm pwd** ☐ **2.4 gm pwd**			
☐ **Velphoro**	☐ **500 mg**	☐ **Take 1 tablet PO TID.** ☐ _____		
☐ **Lokelma**	☐ **5 gm pwd packet** ☐ **10 gm pwd packet**	☐ **1 packet QD.** ☐ _____		

Ship to: □ Patient □ Office □ Other_____Date:_____ Need by Date_____

Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s) and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorizations forms and the receipt and submission of patient tab values and other patient data, in the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize the pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

□ Product Substitution permitted □ Dispense as Written

Prescriber's Signature:_____Date: _____