P: 832-813-8932

F: 888-883-9901

NEPHROLOGY RX FORM

PATIENT INFORMATION

PATIENT NAME: ______________________________ **DOB** ________/________/_______ **PHONE:** (________) - _________ - ________

PLEASE ATTACH A COPY OF THE PATIENT'S INSURANCE INFORMATION AND DEMOGRAPHICS

MEDICATION

REFILLS
☐ **6 MONTHS**
☐ **1 YEAR**

☐ KRYSTEXXA 8MG EVERY 2 WEEKS
*PREMEDICATE: 80MG SOLUMEDROL IV, 50MG BENADRYL PO, 1000MG TYLENOL PO (30 MIN PRIOR)

INJECTAFER (PLEASE SELECT)
☐ 1500 MG IV GIVEN OVER 2 DOSES, AT LEAST 7 DAYS APART (>110LBS)
☐ 15MG/KG IV GIVEN OVER 2 DOSES, AT LEAST 7 DAYS APART (<110LBS)

☐ MAGNESIUM SULFATE ______ GMS EVERY ______________________
☐ PERIPHERAL IV CAN BE LEFT IN UNTIL TREATMENT COMPLETED

☐ VENOFER _______MG IV FOR ______WEEKS, TOTAL OF _______ DOSES

PRE-MEDICATIONS

BENADRYL IV __________ MG
REGLAN IV __________ MG
SOLUMEDROL IV __________ MG
ZOFRAN IV __________ MG
OTHER IV______________________________ MG

BENADRYL PO __________ MG
TYLENOL PO __________ MG
ZYRTEC PO __________ MG
ZOFRAN PO __________ MG
ZANTAC PO __________ MG
OTHER PO__________________________________ MG

INDICATE IF ADDITIONAL PRE-MEDS ARE NEEDED

IF APPLICABLE, DATE OF LAST INFUSION: ________________

WILL PATIENT BE RE-LOADING? ☐ **YES** ☐ **NO**

MEDICAL INFORMATION

WEIGHT: ___________**LBS** **HEIGHT:** ____________ **IN**
ALLERGIES: ______________________________________ ☐ **N.K.D.A**

DATE OF sUA LEVEL (KRYSTEXXA): ____________
LEVEL: ___________ **MG/DL**

DATE OF eGFR (KRYSTEXXA): ____________
LEVEL: ____________

DATE OF LAST IRON PANEL (IRONS): ____________________
DATE OF LAST CBC: __________________________
HB RESULT: ____________________________ **G/DL**
TSAT RESULT: __________________________ **%**
FERRITIN LEVEL: _______________________ **MCG/DL**

DATE OF LAST LAST MAGNESIUM LEVEL: ________________________
MAGNESIUM LEVEL: _______________

PREVIOUSLY FAILED MEDICATIONS/DOSE:

#1 ______________________________ **DATE RANGE:** ____________
#2 ______________________________ **DATE RANGE:** ____________
#3 ______________________________ **DATE RANGE:** ____________

PATIENT WILL BE DISCONTINUING: ______________________________

PLEASE ATTACH ALL MEDICAL RECORDS, INCLUDING LAB WORK, CLINICAL NOTES, HOSPITALIZATION RECORDS, OR SURGICAL PROCEDURES

PLEASE PROVIDE A STANDING ORDER FOR SUA LEVELS TO BE DRAWN

DIAGNOSIS

IRON DEFICIENCY ANEMIA

☐ D50.0 - IRON DEFICIENCY SECONDARY TO BLOOD LOSS (CHR)
☐ D50.1 - SIDEROPENIC DYSPHAGIA
☐ D50.8 - OTHER IRON DEFICIENCY ANEMIAS
☐ D50.9 - IRON DEFICIENCY ANEMIA, UNSP
☐ D63.0 - ANEMIA IN NEOPLASTIC DISEASE
☐ D63.1 - ANEMIA IN CHRONIC KIDNEY DISEASE
☐ D63.8 - ANEMIA IN OTHER CHRONIC KIDNEY DISEASE

OTHER DIAGNOSIS

☐ OTHER DIAGNOSIS: ______________________________
ICD-10:________________

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing our company (based on preferred location) and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

PHYSICIAN NAME (PRINTED): ____ **NPI:** __________________________________

PHONE: ____________________________ **FAX:** _________________________ **CONTACT PERSON:** ________________________

PHYSICIAN NAME (SIGNED): ____ **DATE:** __________________________________

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