ARANESP®

Please Fax Completed Form To: 888-898-9113

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

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: ________________________________ DOB: ____________

Address: ____

City, State, Zip: ______________________________________

Phone: ___________________ Alt. Phone: ________________

Email: __________________________ SS#: _________________

Gender: ☐ M ☐ F Weight: _______(lbs) Ht: ______________

Allergies: ____

PRESCRIBER INFORMATION

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? ☐ Yes ☐ No Is the patient on dialysis? ☐ Yes ☐ No

Has patient received any ESA therapy? ☐ Yes ☐ No If yes, how many weeks of ESA therapy has the patient completed? __________ weeks

Patient's hemoglobin (Hgb) level: ________________ g/dL

ARANESP® ORDERS

Prescription type: ☐ New start ☐ Restart ☐ Continued therapy Total Doses Received: _________ Date of Last Injection/Infusion: _________

Medication	Dose/Frequency	Refills
☐ Aranesp® (darbepoetin alfa) Single Dose Vials ☐ Aranesp® (darbepoetin alfa) Single Dose Prefilled Syringe	☐ 25 mcg ☐ 40 mcg ☐ 60 mcg ☐ 100 mcg ☐ 150 mcg ☐ 200 mcg ☐ 300 mcg ☐ Other: _____ ☐ Weekly ☐ Every 2 Weeks ☐ Other: ______________	Refills: ________________

Special Instructions: ____

SIGNATURE

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

X____ Date: ________________

Prescriber Signature

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.

Important Information: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee.