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MedRX Infusion
www.medrxinfusion.com

Nephrology Referral Form

Administer At: ☐ Patien's Home ☐ Prescriber's Office ☐ Other:_____ ☐ Hold shipment until notified by prescriber ☐ Anticipated Start Date: _____

1. Patient Information

Last Name:_____

First Name:_____

Date of Birth:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

2. Prescriber Information

Prescriber Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____

NPI# _____ Office Contact:_____

3. Diagnosis and Clinical Information (Please fax recent clinical notes, labs and tests, with the prescription to expedite the prior authorization)

Allergies:_____ Height:_____ Weight:_____

Tried/Failed Meds and Therapies: _____

Diagnosis (ICD 10 Code):_____

4. Prescription Information

Medication	Dose/Strength			Directions	Dispense	Refill
☐ **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. ☐ _____		
☐ **Other**						

Order will include as needed: Anaphylaxis kit, Diluents, Flushes, Supplies. Skilled Home Health nursing services if administered at home

Prescriber Authorization (No stamps. Signature and date must be completed in prescriber's handwriting)

I authorize MedRX Infusion Clinical Pharmacy to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans.

Prescriber Signature PRESCRIBER SIGNATURE REQUIRED. NO STAMPS._____ Date _____