

# ANEMIA REFERRAL FORM

## PATIENT INFORMATION (please attach insurance card)

Name:		<input type="checkbox"/> M	<input type="checkbox"/> F	DoB:	
Street:		City:		State:	Zip:
Phone:	Phone:	Allergies:			

## CLINICAL INFORMATION (please attach clinical notes and labs)

**Diagnosis with ICD-10 code**

**D50.9** iron deficiency anemia     **D61.3** aplastic anemia, idiopathic

**D63.8** anemia due to chronic kidney disease     Other: \_\_\_\_\_

ht: _____ in/cm	<b>Labs</b> (attach results)	<b>Clinical and Treatment History</b>
wt: _____ lb/kg	<input type="checkbox"/> CBC <input type="checkbox"/> CMP	Current medication(s) with date(s) started: _____
BMI: _____	<input type="checkbox"/> iron studies	Prior medication(s) with date(s) of use: _____

## PRESCRIPTION DAW (deliver to patient office)

Medication	Dose/Strength	Directions/Sig	Quantity	Refills
<b>Erythropoiesis-stimulating Agent (ESA)</b>				
<input type="checkbox"/> Aranesp	Inj: <input type="checkbox"/> 25mcg/mL <input type="checkbox"/> 40mcg/mL <input type="checkbox"/> 60mcg/mL <input type="checkbox"/> 100mcg/mL <input type="checkbox"/> 200mcg/mL			
<input type="checkbox"/> Epogen	PF: <input type="checkbox"/> 10mcg/0.4mL <input type="checkbox"/> 25mcg/0.42mL <input type="checkbox"/> 40mcg/0.4mL <input type="checkbox"/> 60mcg/0.3mL <input type="checkbox"/> 100mcg/0.5mL <input type="checkbox"/> 150mcg/0.3mL <input type="checkbox"/> 200mcg/0.4mL <input type="checkbox"/> 300mcg/0.6mL <input type="checkbox"/> 500mcg/mL			
<input type="checkbox"/> Procrit	Inj: <input type="checkbox"/> 10,000 units/mL (2ml) <input type="checkbox"/> 20,000 units/mL (1mL)			
<input type="checkbox"/> Retacrit	PF: <input type="checkbox"/> 2000 units/mL <input type="checkbox"/> 3000 units/mL <input type="checkbox"/> 4000 units/mL <input type="checkbox"/> 10000 units/mL <input type="checkbox"/> 40000 units/mL (Procrit/Retacrit)			
<b>Hypoxia-inducible Factor Prolyl Hydroxylase Inhibitor</b>				
<input type="checkbox"/> Vafseo	<input type="checkbox"/> 150mg tab <input type="checkbox"/> 300mg tab			
<b>Iron Replacement</b>				
<input type="checkbox"/> Feraheme	510mg/17mL	Infuse 510mg IV once weekly x 2 doses	34mL	
<input type="checkbox"/> Injectafer	750mg/15mL	Infuse 750mg IV once weekly x 2 doses	30mL	
<input type="checkbox"/> Venofer	20mg/mL	_____mg IV every _____ days (total 1g)		
<b>Other:</b>				
<input type="checkbox"/> <b>Ancillary Supplies</b>	Check box to authorize ancillary supplies like needles, syringes, sterile water, etc. to administer the therapy	Use as needed to administer prescribed medication		

## PRESCRIBER INFORMATION

Prescriber:		Supervising Physician:			
Contact Name:		Contact Method: <input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Email:			
Phone:		Ext:		Fax:	
Street:		City:		State:	Zip:
Signature:		Date:		NPI:	

\*By signing this form, I authorize Synergen Rx LLC and its employees to act as authorized agents on behalf of my office to obtain prior authorization through my patient's insurance plan and to facilitate the enrollment of the patient into patient assistance programs with manufacturers and other foundations.



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synergenrx.com

# THROMBOCYTOPENIA REFERRAL FORM

## PATIENT INFORMATION (please attach insurance card)

Name: \_\_\_\_\_  M  F DoB: \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_ Allergies: \_\_\_\_\_

## CLINICAL INFORMATION (please attach clinical notes and labs)

**Diagnosis with ICD-10 code**  **D69.3** immune thrombocytopenia purpura  **D69.59** chronic immune thrombocytopenia  
 **D69.59** chronic liver disease-associated thrombocytopenia  **D69.59** hepatitis C-associated thrombocytopenia  
 Other: \_\_\_\_\_

ht: \_\_\_\_\_ in/cm      wt: \_\_\_\_\_ lb/kg      BMI: \_\_\_\_\_

**Labs** (please send most recent results)  CBC with differential  CMP  iron studies

### Clinical and Treatment History

Current medication(s) with date(s) started: \_\_\_\_\_

Prior medication(s) with date(s) of use: \_\_\_\_\_

## PRESCRIPTION

**DAW** (deliver to  patient  office)

Medication	Dose/Strength	Route	Directions/Sig	Quantity	Refills
<b>Thrombopoietin Receptor Agonist</b>					
<input type="checkbox"/> Alvaiz	<input type="checkbox"/> 9mg tab <input type="checkbox"/> 18mg tab <input type="checkbox"/> 36mg tab <input type="checkbox"/> 54mg tab	PO			
<input type="checkbox"/> Mulpleta	3mg tab	PO			
<input type="checkbox"/> Nplate	<input type="checkbox"/> 125mcg SDV <input type="checkbox"/> 250mg SDV <input type="checkbox"/> 500mcg SDV	sub-Q			
<input type="checkbox"/> Promacta	Packet: <input type="checkbox"/> 12.5mg <input type="checkbox"/> 25mg Tablet: <input type="checkbox"/> 12.5mg <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> 75mg	PO			
<b>Other:</b>					
<input type="checkbox"/> <b>Ancillary Supplies</b>	Check box to authorize ancillary supplies like needles, syringes, sterile water, etc. to administer the therapy		Use as needed to administer prescribed medication		

## PRESCRIBER INFORMATION

Prescriber: \_\_\_\_\_ Supervising Physician: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Contact Method:  Phone  Fax  Email: \_\_\_\_\_

Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Fax: \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ NPI: \_\_\_\_\_

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