NEPHROLOGY REFERRAL FORM

Phone: 404-585-7517
Fax: 404-900-9209
NPI: 1811550528
synergenrx.com

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

- ☐ **D50.9** Iron deficiency anemia
- ☐ **E83.39** Hyperphosphatemia in CKD
- ☐ **N25.81** hyperparathyroidism secondary to CKD
- ☐ Other: ________________________
  ICD 10: ________________________

Clinical History

Is patient on dialysis? ☐ yes ☐ no

Dialysis center: ______________________ Phone: ____________________

Dialysis schedule: ____________________ Shift:______________________

Is transferrin saturation ≥ 20%? ☐ yes ☐ no ______________ %

Is serum ferritin ≥ 100ng/mL? ☐ yes ☐ no ______________ ng/mL

Phos _____ mg/dL HGB _____g/dL HCT _____% Fe _____μg/dL

Treatment History

Current medication(s) with date(s) started: ____

Prior medication(s) with dates of use:____

PRESCRIPTION

☐ **DAW** (deliver to ☐ patient ☐ office)

Medication	***Dose/Strength***	***Directions/Sig***	***Quantity***	***Refills***
☐ cinacalcet (Sensipar)	☐ 30mg ☐ 60mg ☐ 90mg	1 tablet PO once/twice *(circle one)* daily		
Phosphorus Binders				
☐ calcium acetate (Phoslo)	667mg capsules	☐ _____ tab by mouth TID with meals ☐ other: ______________________		
☐ lanthanum carbonate (Fosrenol)	**Tabs:** ☐ 500mg ☐ 750mg ☐ 1000mg **Packets:** ☐ 750mg ☐ 1000mg			
☐ sevelamer carbonate (Renvela)	**Tabs:** ☐ 400mg ☐ 800mg **Packets:** ☐ 0.8g ☐ 2.4g			
Parenteral Iron ☐ Feraheme ☐ Injectafer ☐ Venofer	510mg / 17mL 750mg / 15mL 20mg / mL	infuse 510mg IV once weekly x 2 doses infuse 750mg IV once weekly x 2 doses infuse _____mg every ___ days (total 1g)	34mL 30mL _______	
☐ Retacrit	☐ 2,000u/mL ☐ 20,000u/mL ☐ 3,000u/mL ☐ 40,000u/mL ☐ 10,000u/mL ☐ 20,000u/2mL	inject ___________ units subcutaneously 3 times per week		
☐ Vafseo	☐ 150mg ☐ 300mg			
☐ Xphozah	☐ 20mg ☐ 30mg	1 tablet PO twice daily with meals		
Other:				

PRESCRIBER INFORMATION

Prescriber:		Supervising Physician:	
Contact Name:	Contact Method: ☐ Phone ☐ Fax ☐ 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.

SYNERGEN Rx Specialty Pharmacy

Phone: 404-585-7517
Fax: 404-900-9209
NPI: 1811550528
synergenrx.com

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

☐ **D63.8** anemia due to chronic kidney disease ☐ Other: ____________________

ht: __________ in/cm
wt: __________ lb/kg
BMI: ____________

Labs *(attach results)*
☐ CBC ☐ 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*	*Directions/Sig*	*Quantity*	*Refills*
Erythropoiesis-stimulating Agent (ESA)				
☐ Aranesp	*Inj:* ☐ 25mcg/mL ☐ 40mcg/mL ☐ 60mcg/mL ☐ 100mcg/mL ☐ 200mcg/mL *PFS:* ☐ 10mcg/0.4mL ☐ 25mcg/0.42mL ☐ 40mcg/0.4mL ☐ 60mcg/0.3mL ☐ 100mcg/0.5mL ☐ 150mcg/0.3mL ☐ 200mcg/0.4mL ☐ 300mcg/0.6mL ☐ 500mcg/mL			
☐ Epogen ☐ Procrit ☐ Retacrit	*Inj*: ☐ 10,000 units/mL (2ml) ☐ 20,000 units/mL (1mL) *PF*: ☐ 2000 units/mL ☐ 3000 units/mL ☐ 4000 units/mL ☐ 10000 units/mL ☐ 40000 units/mL *(Procrit/Retacrit)*			
Hypoxia-inducible Factor Prolyl Hydroxylase Inhibitor				
☐ Vafseo	☐ 150mg tab ☐ 300mg tab			
Iron Replacement				
☐ Feraheme	510mg/17mL	Infuse 510mg IV once weekly x 2 doses	34mL	
☐ Injectafer	750mg/15mL	Infuse 750mg IV once weekly x 2 doses	30mL	
☐ Venofer	20mg/mL	______mg IV every _____ days (total 1g)		
Other:				
☐ **Ancillary Supplies**	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:

*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.

Phone: 404-585-7517
Fax: 404-900-9209
NPI: 1811550528
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*
Thrombopoietin Receptor Agonist					
☐ Alvaiz	☐ 9mg tab ☐ 18mg tab ☐ 36mg tab ☐ 54mg tab	PO			
☐ Mulpleta	3mg tab	PO			
☐ Nplate	☐ 125mcg SDV ☐ 250mg SDV ☐ 500mcg SDV	sub-Q			
☐ Promacta	*Packet*: ☐ 12.5mg ☐ 25mg *Tablet*: ☐ 12.5mg ☐ 25mg ☐ 50mg ☐ 75mg	PO			
Other:					
☐ **Ancillary Supplies**	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:	

*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.