SYNERGEN Rx Specialty Pharmacy

NEPHROLOGY REFERRAL FORM

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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	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	infuse _____mg every ___ days (total 1g)	_____	
☐ 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.