

SICKLE CELL & IRON OVERLOAD 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

- D56.1** beta thalassemia
 D57.1 sickle cell disease withOUT crisis
 D57.21 sickle cell disease with crisis
 E83.111 chronic iron overload
 Other: _____

Clinical History

ht: _____ in/cm wt: _____ lb/kg

Number of vaso-occlusive crises within the past 12 months: _____

Is patient currently receiving concomitant chronic prophylactic blood transfusion therapy? yes no

Labs and Procedures

(attach copies of most recent results)

- CBC w/diff transferrin
 iron Tsat
 TIBC ferritin

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
<input type="checkbox"/> Adakveo	100mg/10mL	_____mg IV weeks 0 and 2 then every 4 weeks		
<input type="checkbox"/> Endari (L-glutamine)	5g packet	Mix in 8oz cold or warm beverage (water, juice) or 4-6oz soft food (yogurt, applesauce) prior to administration <input type="checkbox"/> (< 30kg) 5g (1 pct) PO BID <input type="checkbox"/> (30-65kg) 10g (2 pct) PO BID <input type="checkbox"/> (> 65kg) 15g (3 pct) PO BID		
Hydroxyurea preps				
<input type="checkbox"/> Droxia	<input type="checkbox"/> 200mg cap <input type="checkbox"/> 300mg cap <input type="checkbox"/> 400mg cap			
<input type="checkbox"/> Hydrea	<input type="checkbox"/> 500mg cap			
<input type="checkbox"/> Siklos	<input type="checkbox"/> 100mg cap <input type="checkbox"/> 1000mg cap			

Iron Overload

<input type="checkbox"/> Desferal (deferoxamine)	<input type="checkbox"/> 500mg <input type="checkbox"/> 2g	Route: <input type="checkbox"/> IM <input type="checkbox"/> IV <input type="checkbox"/> sub-Q Dose: _____		
<input type="checkbox"/> Exjade (deferasirox)	<input type="checkbox"/> 125mg soluble tab <input type="checkbox"/> 250mg soluble tab <input type="checkbox"/> 500mg soluble tab			
<input type="checkbox"/> Jadenu (deferasirox)	Packet: <input type="checkbox"/> 90mg <input type="checkbox"/> 180mg <input type="checkbox"/> 360mg Tablet: <input type="checkbox"/> 90mg <input type="checkbox"/> 180mg <input type="checkbox"/> 360mg			
Other:				

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:	