LAWRENCE COUNTY
Memorial Hospital
DEACONESS ILLINOIS PARTNER

PATIENT INFORMATION

Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

DIAGNOSIS AND ICDE 10 CODE

☐ Anemia due to chronic kidney disease on Dialysis	ICD 10 Code: D63.1
☐ Anemia due to Chronic Kidney Disease NOT on Dialysis	ICD 10 Code: D63.1
☐ Anemia due to chemotherapy in non-myeloid malignancy	ICD 10 Code: D63.0
☐ Other: _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

☐ The signed order form by the provider ☐ Patient demographics AND insurance information ☐ Prior authorization with reference number *Pt may be required to submit a pregnancy test prior to treatment	☐ Clinical/Progress notes (must be within 1 year) ☐ Serum hemoglobin level ☐ Iron Studies ☐ CKD patients: kidney function test (creatinine, eGFR) ☐ Chemo patients: Cancer DX and documentation

List of tried and failed therapies, including duration of treatment:

1) _____
2) _____

MEDICATION ORDERS

Dosing Wt for Calculation: HT: _____ WT (kg): _____ BMI: _____ **Pt wt required for weight-based orders

CKD on Dialysis	☐ J0882 Aranesp _____mcg IV/SubQ once weekly ☐ J0882 Aranesp _____mcg IV/SQ every 2 weeks ☐ J0882 Aranesp _____mcg IV/SQ every _____ weeks Starting dose: 0.45 mcg/kg once weekly OR 0.75 mcg/kg every 2 weeks. IV route recommended for hemodialysis.
CKD NOT on Dialysis	☐ J0882 Aranesp _____mcg IV/SubQ once weekly ☐ J0882 Aranesp _____mcg IV/SQ every 4 weeks ☐ J0882 Aranesp _____mcg IV/SQ every _____ weeks Starting dose: 0.45mch/kg once every 4 weeks or once weekly. Initiate only when Hgb <10g/dL
Chemotherapy Induced Anemia) Non-myeloid malignancies	☐ J0882 Aranesp _____mcg IV/SubQ once weekly ☐ J0882 Aranesp 500mcg SubQ every 3 weeks ☐ J0882 Aranesp _____mcg IV/SQ every _____ weeks Initiate only if Hgb <10g/dL and minimum 2 months of planned chemotherapy remaining. Discontinue after chemotherapy completion.

Duration: ☐ x3 months ☐ x6 months ☐ x 1 year ☐ x _____ doses

PREMEDICATIONS/ LAB ORDERS

INFUSION ORDERS – ARANESP (DARBEPOETIN ALFA)

□ CBC □ prior to each injection or □ Frequency: _____ □ CMP □ prior to each injection or □ Frequency: _____ □ Other: _____ Date: _____
ADDITIONAL ORDERS/INFORMATION
PRESCRIBER INFORMATION

Provider Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date: Time:

ALL INFORMATION COUNTAINED IN THIS ORDER FORM IS STRICTLY CONFIDENTIAL AND WILL BECOME PART OF THE PATIENTS MEDICAL RECORD.

CONTACT US WITH QUESTIONS AT 618-943-8515
FAX COMPLETED FORM AND ALL DOCUMENTS TO 618-943-7242

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