Aranesp®

PRESCRIPTION & ENROLLMENT FORM

❑ New Patient
❑ Current

1 PATIENT INFORMATION

Patient's Name ______
Date of Birth ______ ❑ Male ❑ Female Last 4 digits of SSN______
Street Address ______ Apt#______
City ______ State ______ Zip ______
Parent/Guardian (if applicable) ______
Home Phone ______ Work Phone ______
Cell Phone ______ Evening Phone ______
E-mail address ______
Insurance Company Name ______
Insurance Company Phone No. ______
Insured's Name ______
Insured's Employer ______
Relationship to Patient ______
Identification No.______ Policy/Group No. ______
Prescription Card ❑ No ❑ Yes If Yes, Carrier ______
Policy No. ______ Group No. ______
Is patient eligible for Medicare? ❑ No ❑ Yes **Please attach front and back copy of patient's insurance cards, if available.**

2 PRESCRIBER INFORMATION

Prescriber's Name ______
Office Contact ______
Clinic / Hospital Affiliation ______
Street Address______Suite # ______
City ______ State ______ Zip ______
Phone ______ Fax ______
NPI No. ______ License No. ______
DEA No. ______
Physician Medicaid UPIN No. ______
MD Specialty ______

To reach your team, call toll-free 1 888 762-4002.

Please fax completed form to the Aranesp team 1 888 302-1028.

3 CLINICAL INFORMATION

Primary ICD-9 Code: ______ ______

Current Weight______ kg/lbs Date Recorded

Laboratory Results: Hematocrit______% Hemaglobin______g/dl Platelets______
Date______ Date______ Date______

EXPECTED DATE OF FIRST/NEXT INJECTION:______ DATE OF LAST INJECTION (if applicable):______

Agency nurse to visit home for injection: ❑ Yes ❑ No
Agency Name & Phone: ______

Rx: ❑ Aranesp® (darbepoetin alfa)

❑ 25 mcg ❑ 40 mcg ❑ 60 mcg
❑ 100 mcg ❑ 150 mcg ❑ 200 mcg
❑ 300 mcg ❑ 500 mcg

❑ SureClick ❑ Prefilled Syringe ❑ vial

SIG: Inject Dose: ______ mcg/kg or ______mcg
Route: ❑ IV ❑ SC Frequency:______
Dispense Quantity:______ Refills:______

Supplies (if needed per dose): ❑ 1 ml syringe ❑ 3 ml syringe
❑ 7G 5/8" needle ❑ 25G 5/8" needle ❑ 271/2G 5/8"0 Pediatrics Only

❑ NKDA ❑ Known Drug Allergies:______

Deliver product to: ❑ Office ❑ Patient's Home ❑ Clinic / Clinic Location

______

If shipped to physician's office, physician accepts on behalf of patient for administration in office

By signing below, I certify that the above therapy is medically necessary.

Prescriber's Printed Name ______
Prescriber's Signature (sign below) **Date** ______

______ ______
Dispense as Written **Substitution Allowed**

(Physician attests this is his/her legal signature. **NO STAMPS**)

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