

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 _____
 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 1 888 608-9010.

**Please fax completed form to the Deep Vein Thrombosis team
1 888 302-1028.**

3 CLINICAL INFORMATION

Primary ICD-9 Code: _____

Laboratory Results:

Hematocrit _____% Hemaglobin _____g/dl Platelets _____
 Date _____ Date _____ Date _____
 CrCl _____ml/min 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:

Arixtra® (fondaparinux sodium)

DVT/PE Treatment 05 mg (wt<50 kg) 7.5 mg (wt 50-100 kg) 10 mg (wt>100 kg)

Prophylaxis 2.5 mg Other _____

Fragmin® (dalteparin sodium) DVT Prophylaxis

2500 units (abdominal surgery)

5,000 units (high risk abdominal surgery, hip replacement medically ill)

120 units/kg (acute coronary syndrome, assoc. w/unstable angina or Non-Q Wave myocardial infarction) Other _____

Innohep® (tinzaparin sodium)

175anti-Xa int. units/kg

Lovenox® (enoxaparin sodium) DVT Prophylaxis

30 mg (hip/knee replacement surgery)

40 mg (abdominal surgery, acute medically ill) Other _____

DVT Treatment or unstable angina

1 mg/kg Other _____

SIG: Dose: _____ mg for inhalation using recommended nebulizer

Frequency: _____

Dispense Quantity: _____ Refills: _____

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**)