

ARANESP®

Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Complete or Fax Existing Chart)		PRESCRIBER INFORMATION	
Name: DOB:		Prescriber Name:	
Address:		State License:	
City, State, Zip:		NPI #: DEA:	
Phone: Alt. Phone:		Address:	
Email: SS#:		City, State, Zip:	
Gender: 🗆 M 🗆 F Weight:(lbs) Ht:		Phone: F	
Allergies:		Office Contact:	Phone:
INSURANCE INFORMATION – OR – Send a copy of the patient's prescription/insurance cards (front & back)			
Primary Insurance:		RX Card (PBM):	
City, State, Zip:		BIN: PCN:	
Plan #:		City, State, Zip:	
Group #:		Group #:	
Phone:		Phone:	
Secondary Insurance (If Applicable):			
Secondary Insurance:		City, State, Zip:	
Plan #:		Group #:	
Phone:			
CLINICAL INFORMATION			
Primary ICD-10 (Please Specify Diagnosis):		econdary ICD-10 (Please Specify Diagnosis):	
Tertiary ICD-10 (Please Specify Diagnosis):			
Is the patient on iron, folate and/or vitamin B12 therapy? 🗌 Yes 🗌 No 🛛 Is the patient on dialysis? 🗌 Yes 📄 No			
Has patient received any ESA therapy? 🗆 Yes 🛛 No 🛛 If yes, how many weeks of ESA therapy has the patient completed? weeks			
Patient's hemoglobin (Hgb) level:			·
ARANESP [®] ORDERS			
Prescription type: 🗌 New start 🛛 Restart 🔲 Continued therapy 🛛 Total Doses Received: Date of Last Injection/Infusion:			
Medication	Dose	e/Frequency	Refills
□ Aranesp [®] (darbepoetin alfa) Single	□ 25 mcg □ 40 mcg	🗆 60 mcg 🛛 100 mcg	
Dose Vials	🗆 150 mcg 🛛 🗆 200 mcg	□ 300 mcg □ Other:	Refills:
Aranesp [®] (darbepoetin alfa) SingleDose Prefilled Syringe	Weekly Every 2 Weekly	eks 🗌 Other:	
Special Instructions:			
SIGNATURE			
We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.			
Х		Date:	
Prescriber Signature			

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

Important Information: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the material. In no event should such material be read by anyone other than the named addressee.