Advanced Pharmacy
& Respiratory Care
Solutions

"Personalized Specialty Healthcare"
26611 Cabot Rd.
Laguna Hills, CA 92653

Anemia Referral

Patient Information	Physician Information
Patient Name:	Physician Name:
DOB: Sex:☐ M ☐ F	Lic# NPI:
Address:	Address:
City/State/Zip	City/state/zip:
Phone:	Phone Fax:
Alt Phone:	Office Contact : ext:

Insurance Information:	
Primary Insurance:	Secondary Insurance:
Subscriber:	Subscriber:
ID#:	ID#:
Group Policy:	Group Policy:
Phone:	Phone:
Employer:	Employer:

Prescription:	DOSE/Directions:
Aranesp® (darbepoetin alpha)/1mcg	Single-use vial: ☐25 mcg/ml ☐ 40 mcg/ml ☐60 mcg/ml ☐100 mcg/ml ☐ 150 mcg/.75ml 200 mcg/ml Single-use pre-filled syringe: ☐25 mcg/0.42ml ☐40 mcg/0.4ml ☐60 mcg/0.3ml ☐100 mcg/0.5ml ☐150 mcg/0.3ml ☐ 200 mcg/0.4ml ☐300 mcg/0.6ml ☐500 mcg/ml ☐ 300mcg/ml SDPF Sig: ______ ____________________refill
Epogen® (epoetin alpha)/1000u	☐ 2000 units/ml Single dose vial ☐ 3000 units/ml Single dose vial ☐ 4000 units/ml Single dose vial ☐ 10000 units/ml Single dose vial ☐10000 units/ml Multi dose vial ☐ 20000 units/ml Multi dose vial Sig: ____ Q ____ ____________ refills
Procrit® (epoetin alpha)/1000u	☐ 2000 units/ml Single dose vial ☐ 3000 units/ml Single dose vial ☐ 4000 units/ml Single dose vial ☐ 10000 units/ml Single dose vial ☐10000 units/ml Multi dose vial ☐ 20000 units/ml Multi dose vial ☐ 10000 SDPF Sig: _______________ Q ________________ refills____________
(write in additional RX)	

Diagnosis/Statement of Medical Necessity: (please include all relevant documentation when faxing)

Signature: ___________________________ Date: ______________________

Fax to 949-582-6111