PREMIER
PHARMACY SERVICES

Fax: 800.540.3400
Phone: 800.540.4700

To ePrescribe, send prescription to:
Premier Pharmacy Services
410 Cloverleaf Drive
Baldwin Park, CA 91706

NEPHROLOGY ORDER FORM

Patient Information

Patient Name: _____ DOB: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Alt Phone: _____ Alternate Contact Info: _____

Gender: ☐ Male ☐ Female Allergies: _____ E-Mail: _____

PATIENT CONSENT (Patient, please initial)

By initialing in the space provided, you are agreeing to receive text messages sent by Premier Pharmacy Services' via automated technology to the mobile phone number provided. Message and data rates may apply. You may text STOP to 97595 to opt-out (you will be sent a confirmation message) or call 800-540-4700 x625

_____ Initial

PLEASE ATTACH COPIES OF FRONT AND BACK OF PATIENT'S PRESCRIPTION INSURANCE CARDS

Clinical

LABS

Serum Calcium:	
Date:	
Serum Phosphorus:	
Date:	
25-Hydroxyvitamin D:	
Date:	
Intact Parathyroid Hormone:	
Date:	

DIAGNOSIS

Date of Diagnosis: _____ CKD Stage: _____

- ☐ N25.81 Secondary hyperparathyroidism in adults w/stage 3 or 4 CKD and serum total 25-hydroxyvitamin D levels <30ng/ml.
- ☐ N25.81 Secondary hyperparathyroidism in adults w/ CKD on dialysis
- ☐ N18.6 End stage renal disease
- ☐ N25.0 Renal osteodystrophy
- ☐ E83.3 Disorders of phosphorus metabolism and phosphatases
- ☐ E83.30 Disorder of phosphorus metabolism, unspecified
- ☐ E83.39 Other disorders of phosphorus metabolism
- ☐ E21.3 Hypercalcemia in adult patients with parathyroid carcinoma
- ☐ E21.0 Primary hyperparathyroidism
- ☐ E86.1 Euvolemic hyponatremia including patients with heart failure and syndrome of inappropriate antidiuretic hormone (SIADH)
- ☐ E87.1 Hypervolemic hyponatremia including patients with heart failure and syndrome of inappropriate antidiuretic hormone (SIADH)

☐ Other: _____

TRIED AND FAILED HISTORY

Previous therapy:
☐ Sevelamer carbonate ☐ Calcium acetate capsules ☐ Velphoro ☐ Sevelamer hydrochloride
☐ Calcium acetate oral solution ☐ Lanthanum carbonate ☐ Ferric citrate ☐ Other: _____

Duration: _____ **Response:** ☐ ☐ Intolerant ☐ Ineffective ☐ Contraindicated ☐ Side Effects: _____
☐ Other response: _____

Prescription

MEDICATION	DIRECTIONS	QTY	REFILLS
☐ Rayaldee ER 30mcg capsules *(calcifediol)*	☐ Take 1 capsule (30mcg) by mouth every day at bedtime *(serum calcium should be below 9.8mg/dL before initiating treatment)*	30 caps	_____
	☐ Take 2 capsules (60mcg) by mouth daily after 3 months if intact PTH is above the treatment goal *(ensure serum calcium is below 9.8mg/dL, phosphorus is below 5.5mg/dL, and 25-hydroxyvitamin D is below 100ng/mL before increasing dose)*	60 caps	_____
☐ Velphoro 500mg chewable tablets *(sucroferric oxyhydroxide)*	☐ Chew or crush 1 tablet by mouth three times daily with meals	90 tabs	_____
☐ Renvela 800mg tablet ☐ Renvela packet 0.8g ☐ Renvela packet 2.4g *(sevelamer carbonate)*	**If Serum Phosphorus is >5.5 and <7.5mg/dL:** ☐ Take 0.8g by mouth three times daily with meals	30 days supply	_____
	If Serum Phosphorus is ≥7.5mg/dL: ☐ Take 1.6g by mouth three times daily with meals	30 days supply	_____
	Titration dose: _____ *(Prescriber, please indicate titration directions)* **Titration dosing guide:** Titrate by 800mg/dose in 2 week intervals (max daily dose in CKD patients on dialysis = 14g)	30 days supply	_____

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Prescription

MEDICATION	DIRECTIONS	QTY	REFILLS
☐ Sevelamer hydrochloride 800mg tablet	**If Serum Phosphorus is >5.5 and <7.5mg/dL:** ☐ Take 1 tablet by mouth three times daily with meals **If Serum Phosphorus is ≥7.5 and <9.0mg/dL:** ☐ Take 2 tablets by mouth three times daily with meals **If Serum Phosphorus is ≥9.0mg/dL:** ☐ Take 2 tablets by mouth three times daily with meals Titration dose: _____ *(Prescriber, please indicate titration directions)* **Titration dosing guide:** Titrate by 1 tablet per meal in 2 week intervals to target serum phosphorus levels 3.5-5.5mg/dL (max daily dose = 15g)	90 tabs 180 tabs 180 tabs 30 days supply	_____ _____ _____ _____
☐ Sevelamer hydrochloride 400mg tablet	**If Serum Phosphorus is >5.5 and <7.5mg/dL:** ☐ Take 2 tablets by mouth three times daily with meals **If Serum Phosphorus is ≥7.5 and <9.0mg/dL:** ☐ Take 3 tablets by mouth three times daily with meals **If Serum Phosphorus is ≥9.0mg/dL:** ☐ Take 4 tablets by mouth three times daily with meals Titration dose: _____ *(Prescriber, please indicate titration directions)* **Titration dosing guide:** Titrate by 1 tablet per meal in 2 week intervals to target serum phosphorus levels 3.5-5.5mg/dL (max daily dose = 15g)	180 tabs 270 tabs 360 tabs 30 days supply	_____ _____ _____ _____
☐ Sensipar tablet ☐ *Generic cinacalcet hydrochloride* ☐ 30mg ☐ 60mg ☐ 90mg	☐ Take 1 tablet by mouth every day ☐ Take 1 tablet by mouth twice a day ☐ Other: _____	30 tabs 60 tabs _____	_____ _____ _____
☐ Samsca tablet ☐ *Generic tolvaptan* ☐ 15mg ☐ 30mg	☐ Take 1 tablet by mouth every day ☐ Other: _____	30 tabs _____	_____ _____
☐ Other: _____	Directions: _____	_____	_____

Prescriber Information

PRIOR AUTHORIZATION

Prescriber Name: _____ NPI: _____ DEA: _____ LIC#: _____

Address: _____

City: _____ Zip: _____ Tel: _____ Fax: _____

Contact Person: _____ E-Mail: _____

PRESCRIBER SIGNATURE
(Prescriber, please sign and date below)

No stamps. Signature and date must be completed in prescriber's handwriting.
NY prescriptions must be submitted via e-script.

I authorize Premier Pharmacy and its representatives to act as an agent to initiate and execute prior authorization for the above patient in order to expedite the process, please provide chart notes and most recent labs.

Physician's Signature: _____ ☐ **Dispense as written (DAW) Date:** _____/_____/_____