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 Name: ____________________ Alt Contact Phone: __________________

Allergies: ________________________ E-Mail: ________________________

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)*	30 days supply	______
	Titration dosing guide: Titrate by 800mg/dose in 2 week intervals (max daily dose in CKD patients on dialysis = 14g)		

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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	90 tabs	________
	If Serum Phosphorus is ≥7.5 and <9.0mg/dL: ☐ Take 2 tablets by mouth three times daily with meals	180 tabs	________
	If Serum Phosphorus is ≥9.0mg/dL: ☐ Take 2 tablets by mouth three times daily with meals	180 tabs	________
	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)	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	180 tabs	________
	If Serum Phosphorus is ≥7.5 and <9.0mg/dL: ☐ Take 3 tablets by mouth three times daily with meals	270 tabs	________
	If Serum Phosphorus is ≥9.0mg/dL: ☐ Take 4 tablets by mouth three times daily with meals	360 tabs	________
	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)	30 days supply	________
☐ Sensipar tablet ☐ *Generic cinacalcet hydrochloride* ☐ 30mg ☐ 60mg ☐ 90mg	☐ Take 1 tablet by mouth every day	30 tabs	________
	☐ Take 1 tablet by mouth twice a day	60 tabs	________
	☐ Other: ______________________________	________	________
☐ Samsca tablet ☐ *Generic tolvaptan* ☐ 15mg ☐ 30mg	☐ Take 1 tablet by mouth every day	30 tabs	________
	☐ Other: ______________________________	________	________
☐ 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:** ______/______/______

IMPORTANT NOTICE: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone.