FirstHealth OF THE CAROLINAS

7096.08.16138.00 Sunset Date: 6/2024

OP Aranesp Referral

1POREF001

Place Patient Label Inside This Box

***** This section refers to the entire plan. If individual orders need a different interval, please indicate in each section below*****

Version 06/2021

Date of Infusion: _____

Patient Name: _____

Patient SSN (if available): _____

Insurance Name: _____

Secondary Insurance: _____

Diagnosis Code: _____

Diagnosis Code Description: _____

Lead Physician _____

Date of Birth: _____

Contact Number: _____

Policy Number: _____

Policy Number: _____

Precertification: ☐ Initiated ☐ Complete

Location to be Performed:
☐ Moore Regional Hospital (MRH)
☐ Montgomery Memorial Hospital (MMH)

Interval _____ Day _____ of every _____ month

Minimum Separation _____ days / weeks (circle one)

Next Due Date _____

Duration: ☐ Until discontinued ☐ ____ Treatments
☐ Until _____

Nursing Orders	**Interval**	**Duration**
☐ Nursing communication If Hemogobin is < or = 8 And > 11, HOLD INJECTION for the day until it's < 11 and decrease the next scheduled dose by 25%.	_____	_____

Lab

Fh Op Aranesp Labs

☐ POCT I-STAT EC4+	_____	_____
☐ Ferritin	_____	_____
☐ Iron and TIBC	_____	_____

Medications

☐ darbepoetin alfa (ARANESP) injection sq every 30 days ☐ 25mcg ☐ 40mcg ☐ 60mcg ☐ 100mcg ☐ 300mcg	_____	_____

Provider Communication

☐ Physician communication order Target HgB Range _____	_____	_____

For Scheduling Fax Forms to: (910) 715-1177.

Provider Signature: _____ Date: _____ Time: _____

* May be used as EPIC Downtime Form