ARANESP®
(darbepoetin alfa)

Treatment referral form

Please submit this completed form with a patient face sheet and supplemental relevant clinical notes. Fax completed form and additional documentation to treating site.

Referring Physician Information

Ordering Physician Name: _____ NPI #: _____
Specialty: _____
Site Name: _____
Address: _____ City: _____ State: _____ ZIP Code: _____
Phone: _____ Fax: _____
Office Contact: _____

Treatment Site Information

Physician Name: _____ NPI #: _____
Specialty: _____
Site Name: _____
Address: _____ City: _____ State: _____ ZIP Code: _____
Phone: _____ Fax: _____
Office Contact: _____

Patient Information

Fill out entirely OR **attach patient face sheet**

Patient Name: _____ Date of Birth: _____ Social Security Number: _____ M ❑ F ❑
Address: _____ City: _____ State: _____ ZIP Code: _____
Work Phone: _____ Cell Phone: _____ Email: _____

Insurance Information

Fill out primary insurance plan name and member insured AND attach patient face sheet with insurance information OR **fax a copy of insurance card, front and back**

Primary Insurance: _____ Secondary Insurance: _____
Insured: _____ Insured: _____
Insurance Phone: _____ Insurance Phone: _____
Policy #: _____ Policy #: _____

Patient Medical Information

Primary Diagnosis Code: _____ Additional secondary ICD-10 Code, if applicable: _____
Type(s) of Labs Completed (if any): _____ Date: _____
ARANESP® is medically necessary for (Patient's Name): _____ as documented by: _____

Contraindications (if any): _____
Patient Is currently taking the following supplemental agents: _____

Product Information

Product Name/Strength: _____

Directions: _____

Prescriber Signature: _____

ACTION: **FAX BACK INJECTION CONFIRMATION FROM TREATING SITE.**
Please update the referring physician by faxing back this form.

ARANESP® Treatment Status at Our Facility:

Was the patient injected with ARANESP®? If yes, provide the date. ❑ **Yes** ❑ **No** **Date:** _____
To date, patient has received _____ doses of ARANESP®.
Has the patient's appointment been scheduled for their next ARANESP® dose? If yes, provide the date. ❑ **Yes** ❑ **No** **Date:** _____

Administering Healthcare Professional's Comments: _____

Please contact Amgen® SupportPlus or AmgenSupportPlus.com for insurance verification or any questions regarding coding/billing, claims submission, and other payer requirements.

Please see Full Prescribing Information, including **BOXED WARNINGS**, and Medication Guide for ARANESP®.

AMGEN®

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