WELLPARTNER PHARMACY | ARANESP® ENROLLMENT FORM

Wellpartner

FAX FORM TO: 1.877.597.3070 | **PHONE:** 1.800.473.3516 | **EMAIL:** specialty@wellpartner.com

Complete the following or include demographic sheet.

1. PATIENT INFORMATION

Name:

Address:

City, State, ZIP:

Primary Phone: - - DOB: / /

Alternate Phone: - - Gender:

Email:

Primary Language: Last Four of SSN:

2. PRESCRIBER INFORMATION

Name:

DEA #: NPI #: State Lic. #:

Group or Hospital:

Address:

City, State, Zip:

Phone: - - Fax: - -

Contact Person: Phone: - -

3. INSURANCE INFORMATION

*Fax copy of **prescription** and **insurance cards** with this form, if available (front and back)*

Primary Insurance Company Name:

Primary Cardholder Name:

Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent

Phone: - - Member ID: Group #:

Secondary Insurance Company Name:

Secondary Cardholder Name:

Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent

Phone: - - Member ID: Group #:

4. DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: / / Ship to: ◯ Patient ◯ Office ◯ Other:

DIAGNOSIS

Date of Diagnosis: / /

◯ D63.1 Anemia in chronic kidney disease

◯ _____ Anemia in cancer patients receiving chemotherapy

Type of Caner: _____

◯ Other: _____

Height (in/cm): Weight (lb/kg):

Date Drawn: / /

LAB DATA

Date Drawn: / /

Hct: Hgb:

GFR (ml/min): Serum iron (Fe):

Allergies:

Concomitant Medications:

EPOETIN CONVERSION FOR ADULTS

2-3 times/week epoetin dosing conversionto once a week			Once-a-week epoetin dosing conversion to every other week		
Aranesp dose (once a week)	→	Epoetin total dose for one week	Epoetin total combined dose for two weeks	→	Aranesp dose (every other week)
<1,500u	→	6.25 mcg	<1,500u	→	6.25 mcg
2,500-4,999u	→	12.5 mcg	2,500-4,999u	→	12.5 mcg
5,000-10,999u	→	25 mcg	5,000-10,999u	→	25 mcg
11,000-17,999u	→	40 mcg	11,000-17,999u	→	40 mcg
18,000-33,999u	→	60 mcg	18,000-33,999u	→	60 mcg
34,000-89,999u	→	100 mcg	34,000-89,999u	→	100 mcg
>90,000u	→	200 mcg	>90,000u	→	200 mcg

Specialty pharmacy to coordinate injection training/home health nurse as necessary:

◯ Yes ◯ No ◯ Injection training not necessary

Reason:

◯ MD office trained patient ◯ Patient already independent ◯ Referred by MD office to alternate trainer

5. PRESCRIPTION INFORMATION

Medication	Form	Dose/Strength	Directions	Quantity	Refills
◯ Aranesp®	◯ Sureclick Autoinjector ◯ Singleject PFS	◯ 25 mcg ◯ 150 mcg ◯ 40 mcg ◯ 200 mcg ◯ 60 mcg ◯ 300 mcg ◯ 100 mcg ◯ 500 mcg	◯ Inject the entire contents of syringe SQ once a week. ◯ Inject the entire contents of syringe SQ once every 2 weeks. ◯ Other: _____ ◯ Include alcohol pads and sharps container		
◯					

Ancillary supplies and kits will be provided as needed for administration.

6. PRESCRIBER SIGNATURE

X / /

DISPENSE AS WRITTEN DATE

X / /

PRODUCT SUBSTITUTION PERMITTED DATE