

JADENU REFERRAL FORM



Patient Information

Patient Name: _____ DOB: _____ Sex: M F
 Phone: _____ Cell Phone: _____ Email Address: _____
 Address: _____ City: _____ State: _____ Zip: _____
 ICD-10 Diagnosis Code: _____ Diagnosis: _____ Weight: _____
 Allergies (please note reaction): _____ Latex
 Current Medications: (list here or attach a medication list): _____
 Comorbidities: (list here or attach a list): _____

INSURANCE INFORMATION - FAX COPY OF PATIENT'S INSURANCE CARD

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Jadenu (desferasirox)	<input type="checkbox"/> Tablet	<input type="checkbox"/> Take 90mg by mouth once daily. (Total daily dose _____mg)		
	<input type="checkbox"/> Sprinkle	<input type="checkbox"/> Take 180mg by mouth once daily. (Total daily dose _____mg)		
		<input type="checkbox"/> Take 360mg by mouth once daily. (Total daily dose _____mg)		

Treatment History: New to Therapy Continuation of Therapy

Is the patient taking Jadenu for the first time? Yes No
 If Yes, has patient been previously treated with Exjade? Yes No
 If Yes, Exjade dose: _____mg per day
 If No, original start date: _____
 Serum Ferritin Level: _____mcg/L; Date: _____
 If Non-Transfusion-Dependent Thalassemia Syndrome:
 Liver Iron Concentration: _____mg Fe/g dw; Date: _____

Serum Creatinine: _____mg/dL
 Creatinine Clearance: _____mL/min; Date: _____
 Does the patient have hepatic impairment? Yes No
 If Yes, Child-Pugh score: _____
 Auditory Exam Completed? Yes No
 If Yes, date: _____
 Ophthalmic Exam Completed? Yes No
 If Yes, date: _____

Prescriber Information

Prescriber Name: _____
 State License #: _____ DEA #: _____ NPI: _____
 Additional Contact Person Name: _____
 Group or Hospital: _____ Phone: _____
 Fax: _____ Email Address: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Prescriber Signature: _____
 Product Substitution Permitted Dispensed as Written Date

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Delivery Information

Ship to Patient Ship to Prescriber/Clinic Pick up at Albertsons Companies Pharmacy Date Medication Needed: _____

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It's as simple as caring.