JADENU REFERRAL FORM

www.albertsons.com/specialtycare • Phone: 877.466.8028 • Fax: 877.466.8040

Albertsons Companies Specialty Care

Jewel Osco · Albertsons · SAFEWAY · VONS · ACME · shaw's · star market · PAVILIONS · CARRS · Randalls · Tom Thumb

Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F

Phone: _____ Cell Phone: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

ICD-10 Diagnosis Code: _____ Diagnosis: _____

Allergies (please note reaction): _____ ☐ Latex

Current Medications: (list here or attach a medication list): _____

_____

Comorbidities: (list here or attach a list): _____

Prescription Information

INSURANCE INFORMATION - FAX COPY OF PATIENT'S INSURANCE CARD - BOTH SIDES

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Jadenu (desferasirox)	☐ Tablet ☐ Sprinkle	☐ Take 90mg by mouth once daily. (Total daily dose_____mg) ☐ Take 180mg by mouth once daily. (Total daily dose_____mg) ☐ Take 360mg by mouth once daily. (Total daily dose_____mg)	30-day supply	

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: _____

Serum Creatinine: _____mg/dL

Creatinine Clearance: _____ mL/min; 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: _____

Confidentiality Warning: The information contained in this facsimile message is privileged and confidential information intended only for the review and use of the individual or entity to which it is addressed. If the reader of this message is not the intended recipient, you are hereby notified that any disclosure, dissemination, distribution or copying of this communication of the information contained herein is strictly prohibited. If you have received this communication in error, please immediately notify sender by telephone, and destroy the original documents.

It's as simple as **caring.**

Ph. 800-834-8778
Fax 877-466-8040

E-Scribe Information:
Albertsons/Safeway Pharmacy • 12874 E. Florence Ave.
Santa Fe Springs, CA 90670 • NCPDP 5617418 • NPI 1164451100