Infusion ASSOCIATES

Phone: 616-954-0600 Fax: 616-954-1675

Procrit/Aranesp/Retacrit subcutaneous injection

*Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, and Current Medications and **Recent Visit Notes***

NOTE: If patient is on hemodialysis they can NOT receive Procrit, Retacrit, or Aranesp.

Date: _____/_____/_____

Patient Name: _____ **DOB**: _____/_____/_____

Allergies: _____ **Patient Weight:** _____lbs / kg **Height:**_____

Diagnosis Codes (*check all that apply***):**

- ☐ Anemia in Chronic Kidney Disease D63.1

AND

- ☐ CKD Stage 3 N18.3_____ *(requires 5th character)*
- ☐ CKD Stage 4 N18.4
- ☐ CKD Stage 5 N18.5
- ☐ Other ICD-10 code: _____

Is patient on hemodialysis? ☐ **No** ☐ **Yes**

Current Labs: Date Drawn: ___/___/_____ **Hemoglobin** (hgb): _____ **Hematocrit** (hct): _____

Injection will be held if hemoglobin level is ≥ 11
Requires hemoglobin within 30 days

Labs to be collected: ☐ BMP ☐ CBC w/o diff ☐ CBC w/diff ☐ Renal Panel ☐ CMP ☐ Other: _____

Lab Frequency: ☐ EVERY injection ☐ Monthly ☐ Other:_____

☐ Procrit _____units Subcutaneously WEEKLY x4 QOW x2 MONTHLYx1 OTHER_____

☐ Aranesp _____mcg Subcutaneously WEEKLY x4 QOW x2 MONTHLYx1 OTHER_____

☐ Retacrit _____units Subcutaneously WEEKLY x4 QOW x2 MONTHLYx1 OTHER_____

Printed provider name: _____

Provider signature: _____

Office phone number: _____ **Fax number:** _____