FAST
A FACTOR ONE SOURCE PHARMACY

FAX 1-844-504-3278
PHONE 1-877-327-8881
www.FASTACCESSRX.com

NEPHROLOGY FORM

PATIENT INFORMATION:

Patient Name:_____
Date of Birth:_____Male: ☐ Female: ☐
Address:_____
City/State/Zip:_____
Tel:_____Alt Tel:_____
SS#:_____Wt:_____Ht:_____
NKDA: ☐ Allergy:_____
Emergency Contact:_____

INSURANCE INFORMATION:

Primary Pharmacy Insurance_____
Member Name:_____
Member ID:_____
Rx Group #:_____
BIN#_____PCN#_____
Customer Service #:_____

Please attach a copy of the front and back of the patient's insurance card, if available.**

DIAGNOSIS AND CLINICAL INFORMATION:

Diagnosis/ICD-10:_____

Lab Results: Hematocrit:_____% Hemoglobin:_____% Platelets:_____
Date:_____ Date:_____ Date:_____
Serrum Ferriten:_____ng/ml Transferrin Saturation(TSAT):_____
Date:_____ Date:_____

PRESCRIBER INFORMATION:

Prescriber Name:_____Specialty:_____
Address:_____City/State/Zip:_____
Contact Name:_____Phone #:_____Fax #:_____
NPI#:_____DEA #:_____UPIN #:_____

By signing this form and using our services, you are authorizing F.A.S.T. to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.

Prescriber Printed Name:_____Date:_____
Prescriber Signature Below: (*Physician attests this is his/her legal signature.* **NO STAMPS**)

_____ _____
Substitution Allowed *Dispense as Written*

PRESCRIPTION:

Medication	Strength	Directions	Quantity	Refills
☐ Aranesp®	_____	_____	1 month	_____
☐ Epogen®	_____	_____	1 month	_____
☐ Procrit®	_____	_____	1 month	_____
☐ Rayaldee®	☐ 30 mcg ☐ 60 mcg	Take 1 capsule by mouth daily	1 month	_____
☐ Samsca®	_____	_____	1 month	_____
☐ Sensipar®	_____	_____	1 month	_____
☐ Zemplar®	_____	_____	1 month	_____

Supplies: If needed ☐ 25G 5/8" 3ml ☐ 27G 5/8" 1ml