Place Sticker Here

McLeod Health

Epoetin Alfa Treatment Plan

Patient Name: _____ DOB: _____

Height (cm): _____ Weight (kg): _____ Allergies:_____

Diagnosis (choose from the options below):

□ D63.1 Anemia in Chronic Kidney Disease (select additional code from list below):

- □ N18.3 Chronic Kidney Disease, Stage 3 (moderate)
- □ N18.4 Chronic Kidney Disease, Stage 4 (severe)
- □ N18.5 Chronic Kidney Disease, Stage 5

□ D64.81 Anemia due to Antineoplastic Chemotherapy

List additional cancer code and description: _____

□ D64.9 Anemia, unspecified

□ Other (list ICD 10 code and description): _____

Lab Orders:

- Hemoglobin and Hematocrit prior to each treatment

□ Additional lab orders prior to each treatment (list here): _____

Fax results to physician after each visit: □ Yes □ No

Medication Orders:

- Epoetin alfa subcutaneous injection
  - Dose (select one): □ 10,000 units □ 20,000 units □ 40,000 units □ 60,000 units
  - Frequency (select one): □ Weekly □ Every 2 Weeks □ Every 4 Weeks
- Order Duration: Six months unless otherwise specified (Other: _____)

Parameters:

□ Hold for Hgb ≥ 11 g/dL or Hct ≥ 33%

□ Other Parameters: _____

Physician Signature: _____ **Date:** _____

Physician Name: _____ **Phone:** _____

Approved: 04/2021

Insurance/Authorization Information:

Product Information for Authorization: Epoetin alfa-epbx (Retacrit) (Q5106)

☐ No authorization required (if applicable, please check. No other information required.)

If a different product is requested list name and HCPCS code: _____

Insurance Type: _____

Insurance Authorization Reference Number: _____

Date Obtained: _____ Authorization Valid Until: _____

Additional Notes: _____

Please send history and physical and most recent physician note with completed plan. Fax completed Treatment Plan with authorization information to McLeod Infusion Services at the number below or call with any questions.

Seacoast: 843-366-2224 (Fax)

843-366-3626 (Phone)

Approved: 04/2021