

**Instructions:** Please complete this form and fax to MedImpact Healthcare Systems, Inc. at (858) 790-7100.

**URGENT REQUESTS:** Please check the box(es) below, if applicable. **(Required if Urgent Request):**

- Medication prescribed on hospital discharge or from an emergency medical visit. Date of discharge/visit: \_\_\_\_\_
- Therapy in which a delay may result in significant morbidity or mortality

<u>Patient Name (required):</u>	<u>Patient ID # (required):</u>	<u>Patient DOB (required):</u>
<u>Physician Name:</u>	<u>Physician DEA Number:</u>	<u>Physician Specialty:</u>
<u>Physician Area Code and Telephone Number:</u> (     )     -	<u>Physician Area Code and Fax Number:</u> (     )     -	
<u>Drug Requested:</u> <input type="checkbox"/> Epogen <input type="checkbox"/> Procrit <input type="checkbox"/> Aranesp	<u>Strength:</u>	<u>Dose:</u>
	<u>Expected Duration of Treatment:</u>	
<u>Diagnosis</u>	<u>ICD-9 Code (Required -requests will be returned if not provided)</u>	
<u>Last 2 Hemoglobin/Hematocrit Levels, Including Dates:</u>	<u>Last 2 Serum Creatinine Levels, Including Dates</u> (Required only if patient has renal disease)	
<u>Additional Medical Justification for Requested Therapy</u>		