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600 W Main Street
Suite 120
Troy, OH 45373
Phone: 937-401-6620
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Washington Township Infusion Center
1989 Miamisburg-Centerville Road
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Dayton, OH, 45459
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Aranesp® (darbepoetin) Order Form

Epic Referral: REF115211

Patient Name: _____ **DOB:** _____

Address: _____

Phone: _____ **ICD-10 Diagnosis Code(s):** _____

Labs:

Hemoglobin and Hematocrit will be drawn at each appointment unless labs were recently done.

Other labs to be done _____

Frequency of other labs _____

Rx:

Aranesp Dose: _____mcg subcutaneous injection every (circle one) 1 2 4 6 8 week(s).

If Hgb greater than or equal to _____, hold Aranesp.

If patient's current dose is held for more than 2 sequential encounters, office will be contacted for further direction regarding dose and frequency.

Order Duration:

☐ 1 year ☐ 6 months ☐ 3 months ☐ Other duration: _____

Prescriber Printed Name:_____

Prescriber Full Address: _____

Office Phone Number: _____ **Office Fax Number:** _____

Prescriber Signature: _____ **Date:** _____