



Patient Information: Name: _____ DOB: _____ Gender: M F
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: _____ Alt. Phone: _____ Email: _____ Ht: _____ Wt: _____
 Care Giver: _____ Allergies: No Known See Attached Charts Other: _____

Please include front and back copies of insurance card

Prescriber Information
 Name: _____ NPI: _____ Phone: _____ Fax: _____
 Address: _____ City: _____ State: _____ Zip: _____ Office Contact: _____

Statement of Medical Necessity (Please Attach All Medical Documentation)

Diagnostic Information

Date of Diagnosis: _____ ICD-10: _____ Other: _____

Is patient taking potassium supplements? Yes No

Is patient taking an ACE Inhibitor ARB

I understand Veltassa or Lokelma should not be used as emergency treatment for life-threatening Hyperkalemia Yes

- Injection Training:** Pharmacist to Provide Training
 Patient Trained in MD Office Manufacturer Nurse Support
Product Delivery: Patient's Home Physician's Office
 Pharmacy to Coordinate

Labs	Date
Serum Potassium	
Intact PTH Level	
Serum Creatinine	
Creatinine Clearance	

Medication List and Contraindication(s)
Sodium Polystyrene Sulfonate:
Loop Diuretic:
Thiazide Diuretic:
Calcium:
Insulin:
Other:

Prescription Information:

Medication	Dosage & Strength	Directions	Qty	Refills
<input type="radio"/> Veltassa	<input type="radio"/> 8.4g Powder for Oral Suspension <input type="radio"/> 16.8g Powder for Oral Suspension <input type="radio"/> 25.2g Powder for Oral Suspension	<input type="radio"/> _____ <input type="radio"/> _____ <input type="radio"/> _____		
<input type="radio"/> Lokelma	<input type="radio"/> 5g Powder for Oral Suspension <input type="radio"/> 10g Powder for Oral Suspension	<input type="radio"/> _____ <input type="radio"/> _____		
<input type="radio"/> Other	<input type="radio"/> _____	<input type="radio"/> _____		

Prescriber Signature (I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs)

Signature: _____ Signature _____ Date: _____

Substitution Permitted **Dispense as Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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