# Hyperkalemia-Nephrology

**Call: (877) 883-1392 Fax: (256) 429-2221**

**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: _____

Last 4 of SSN:

**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

| Labs | Date |
|---|---|
| Serum Potassium | |
| Intact PTH Level | |
| Serum Creatinine | |
| Creatinine Clearance | |

**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

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

## Prescription Information:

| Medication | Dosage & Strength | Directions | Qty | Refills |
|---|---|---|---|---|
| ○ Veltassa | ○ 8.4g Powder for Oral Suspension<br>○ 16.8g Powder for Oral Suspension<br>○ 25.2g Powder for Oral Suspension | ○ _____<br>○ _____<br>○ _____ | | |
| ○ Lokelma | ○ 5g Powder for Oral Suspension<br>○ 10g Powder for Oral Suspension | ○ _____<br>○ _____ | | |
| ☐ Other | ○ _____ | ○ _____ | | |

## 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.



**Revised 10/15/2020**