

ERYTHROPOIESIS-STIMULATING AGENTS

(Procrit, Retacrit, Aranesp, Epogen)

Provider Order Form rev. 1/12/2026



AMERICAN
INFUSION CARE

SPECIALTY INFUSION

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Full Name: _____ DOB: _____ Phone: _____ Gender: ☐ M ☐ F ☐ Other

Email Address: _____ Address: _____ Weight (lbs/kg): _____ Height (in): _____

☐ NKDA Allergies: _____ Existing prior authorization? ☐ Yes, (Send a copy) ☐ No (AIC will process)

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

ICD 10-Code & Description (Provide full completed code)

☐ D64.9 Anemia unspecified (includes Anemia due to medications)
☐ D63.1 Anemia in chronic kidney disease (select secondary code to indicate type of CKD)

☐ N18.30 CKD, stage 3 unspecified

☐ N18.4 CKD, stage 4

☐ N18.31 CKD, stage 3a

☐ N18.5 CKD, stage 5

☐ N18.32 CKD, stage 3b ☐ N18.6 End stage renal disease

☐ D64.81 Anemia due to antineoplastic chemotherapy

☐ D61.1 Drug-induced aplastic anemia

☐ Other: _____

REQUIRED DOCUMENTATION: Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results (CBC, CMP, TB, Hep B panel-depending on medication), signed prescription order and recent visit notes.

Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

PRESCRIPTION INFORMATION

Nursing: Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

Pre-Medications

☐ Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mgPO

☐ Cetirizine (Zyrtec) 10mgPO

☐ Loratadine (Claritin) 10mgPO

☐ Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV

☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 125mg IV

☐ Other: _____ Dose: _____ Route: _____

Lab Orders

Required: Hemoglobin (HB) Hematocrit (Hct), Serum Ferritin, TSAT

☐ Other: _____

Therapy Administration: SubQ (Select one):

☐ Procrit (epoetin alpha) - subcutaneous

☐ 50 units/kg ☐ 40,000 units (fixed dose)

☐ 100 units/kg ☐ Other: _____ units

☐ 150 units/kg ☐ Other: _____ units/kg

☐ Retacrit (epoetin alfa-epbx) - subcutaneous

☐ 50 units/kg ☐ 40,000 units (fixed dose)

☐ 100 units/kg ☐ Other: _____ units

☐ 150 units/kg ☐ Other: _____ units

☐ Aranesp (darbepoetin alfa) - subcutaneous

☐ 0.45 mcg/kg

☐ 0.75 mcg/kg every 2 weeks

☐ 200 mcg every 2 weeks

☐ 500 mcg every 3-4 weeks Other: _____ mcg

Epogen (epoetin alpha) - subcutaneous

☐ 50 units/kg

Other: _____ units

☐ 100 units/kg

Other: _____ units/kg

☐ 150 units/kg

☐ 600 units/kg

40000 units

Frequency (check one)

Weekly x 4 doses

Every other week x 2 doses

Monthly x 1 dose

Other: _____

Post Treatment Observations: The patient is required to stay for 30 minutes following the first administration.

☐ Refills: ☐ zero ☐ 6 months ☐ 12 months ☐ _____ (Prescription valid for one year, unless otherwise indicated)

Special Instructions: _____

PROVIDER INFORMATION

Provider Full Name: _____ Provider NPI #: _____ Specialty: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____

Provider Name (Print)

Provider Signature

Date

E: Referrals@americaninfusioncare.com

Americaninfusioncare.com

Greater Houston Area F: 832.510.7824 P: 832.800.3213

McAllen F: 956.302.8906 P: 832.800.3213 Plano: F: 214.831.9829 P: 972.865.4454

Harlingen F: 956.341.9687 P: 832.800.3213 Laredo F: 956.306.3715 P: 832.800.3213

Other Locations (Oaklawn, Lancaster, etc): F: 469.305.2361 P: 972.865.4454