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 × 4 doses
☐ Every other week × 2 doses
☐ Monthly × 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**