JADENU REFERRAL FORM

www.albertsons.com/specialtycare • Phone: 877.466.8028 • Fax: 877.466.8040

Albertsons Companies Specialty Care

Jewel Osco · Albertsons · SAFEWAY · VONS · ACME · shaw's · star market · PAVILIONS · CARRS · Randalls · Tom Thumb

Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F

Phone: _____ Cell Phone: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

ICD-10 Diagnosis Code: _____ Diagnosis: _____

Allergies (please note reaction): _____ ☐ Latex

Current Medications: (list here or attach a medication list): _____

_____

Comorbidities: (list here or attach a list): _____

Prescription Information

INSURANCE INFORMATION - FAX COPY OF PATIENT'S INSURANCE CARD - BOTH SIDES

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Jadenu (desferasirox)	☐ Tablet ☐ Sprinkle	☐ Take 90mg by mouth once daily. (Total daily dose_____mg) ☐ Take 180mg by mouth once daily. (Total daily dose_____mg) ☐ Take 360mg by mouth once daily. (Total daily dose_____mg)	30-day supply	

Treatment History: ☐ New to Therapy ☐ Continuation of Therapy

Is the patient taking Jadenu for the first time? ☐ Yes ☐ No

If Yes, has patient been previously treated with Exjade? ☐ Yes ☐ No

If Yes, Exjade dose: _____ mg per day

If No, original start date: _____

Serum Ferritin Level: _____mcg/L; Date: _____

Serum Creatinine: _____mg/dL

Creatinine Clearance: _____ mL/min; Date: _____

If Non-Transfusion-Dependent Thalassemia Syndrome:

Liver Iron Concentration: ____ mg Fe/g dw; Date: _____

Serum Creatinine: _____ mg/dL

Creatinine Clearance: _____ mL/min; Date: _____

Does the patient have hepatic impairment? ☐ Yes ☐ No

If Yes, Child-Pugh score: _____

Auditory Exam Completed? ☐ Yes ☐ No

If Yes, date: _____

Ophthalmic Exam Completed? ☐ Yes ☐ No

If Yes, date: _____

Prescriber Information

Prescriber Name: _____

State License #: _____ DEA #: _____ NPI: _____

Additional Contact Person Name: _____

Group or Hospital: _____ Phone: _____

Fax: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Prescriber Signature:

_____ _____ _____ _____

Product Substitution Permitted | Date | Dispensed as Written | Date

Delivery Information

Ship to: ☐ Patient ☐ Prescriber/Clinic

☐ Pick up at an Albertsons Companies Pharmacy

Address: _____

Phone: _____

Date Medication Needed: _____

It's as simple as **caring.**

Ph. 800-834-8778
Fax 877-466-8040

E-Scribe Information:
Albertsons/Safeway Pharmacy • 12874 E. Florence Ave.
Santa Fe Springs, CA 90670 • NCPDP 5617418 • NPI 1164451100