SAMSCA REFERRAL FORM

Albertsons Companies Specialty Care | MEDCART SPECIALTY PHARMACY | 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

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Samsca (tolvaptan)	☐ 15mg Tablet	☐ Take 1 tablet by mouth once daily. ☐ Take_____tablets by mouth once daily.	☐ 30 tablets ☐ _____tablets	
	☐ 30mg Tablet	☐ Take 1 tablet by mouth once daily. ☐ Take_____tablets by mouth once daily.		

Treatment History: ☐ New to Therapy ☐ Continuation of Therapy

Inpatient Treatment Initiation Date: _____

Expected Discharge Date: _____

Serum Sodium prior to Samsca initiation: Level: _____mEq/L; Date: _____

Serum Sodium after Samsca initiation: Level: _____mEq/L; Date: _____

Serum Potassium: Level: _____mEq/L; Date: _____

Does the patient have renal impairment? ☐ Yes ☐ No If Yes, Serum Creatinine: _____mg/L Date: _____

Does the patient have hepatic impairment? ☐ Yes ☐ No

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 | Dispensed as Written | Date

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Delivery Information

☐ Ship to Patient ☐ Ship to Prescriber/Clinic ☐ Pick up at Albertsons Companies Pharmacy Date Medication Needed: _____