Hyperkalemia Enrollment Form

PATIENT INFORMATION

Patient Name: _____
Date of Birth: _____ / _____ / _____ ☐ Male ☐ Female
SSN: _____ - _____ - _____
Address: _____
City: _____ State: _____ Zip: _____

Phone: (_____) - _____ - _____
Email: _____
Preferred method of contact: ☐ Phone ☐ Email
Height: _____ in Weight: _____ lb Date: _____ / _____ / _____
Allergies: Medications: (Please attach additional pages if necessary)

PRESCRIPTION BENEFITS INFORMATION (Please attach front and back of insurance card)

Plan name: _____ ID#: _____ Group #: _____ RxBIN: _____ RxPCN: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Contact: _____ Clinic/Hospital Affiliation: _____

Phone: (_____) - _____ - _____ Fax: (_____) - _____ - _____
License #: _____
NPI #: _____
Medicaid Provider #: _____

HYPERKRX-20-01

CLINICAL CONSIDERATIONS

Diagnosis:
☐ E87.5 Hyperkalemia
☐ Other: _____

History of therapies tried/failed (please include dates):

Serum Potassium Level(s): _____ Date:_____
(please attach lab results) _____ Date:_____

℞

Medication	Dose/Strength	Directions	Quantity	Refills
☐ **Veltassa®** Packet (patiromer)	☐ 8.4 grams ☐ 16.8 grams ☐ 25.2 grams ☐ Other: _____	☐ Dissolve contents of one (1) packet into 1/3 cup of water and drink full amount once daily. Take as directed. ☐ Other _____		

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's Signature: _____ ☐ MD ☐ DO ☐ PA ☐ CRNP **Date:** ____ /____ / ____
NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

SHIPPING INFORMATION

Ship to: ☐ Patient ☐ Physician/Clinic Date Shipment Needed By: ____ /____ / ____

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