

# SAMSCA REFERRAL FORM



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): \_\_\_\_\_

## INSURANCE INFORMATION - FAX COPY OF PATIENT'S INSURANCE CARD

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Samsca (tolvaptan)	<input type="checkbox"/> 15mg Tablet	<input type="checkbox"/> Take 1 tablet by mouth once daily. <input type="checkbox"/> Take _____ tablets by mouth once daily.	<input type="checkbox"/> 30 tablets <input type="checkbox"/> _____ tablets	
	<input type="checkbox"/> 30mg Tablet	<input type="checkbox"/> Take 1 tablet by mouth once daily. <input type="checkbox"/> 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: \_\_\_\_\_

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