MATAGORDA REGIONAL
MEDICAL CENTER
MRMC IV THERAPY SERVICES
PHONE: 979-241-5966
FAX: 979-241-5965

RETACRIT (EPOETIN ALFA) ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____ DOB:_____

HT: _____ WT: _____ Sex :( ) Male ( ) Female SSN:_____ Home #:_____ Cell#:_____

Street Address_____ City/State/Zip _____

Allergies:_____

INSURANCE INFORMATION

Primary Insurance Name _____ Policy ID #: _____

Secondary Insurance Name_____ Policy ID #:_____

PHYSICIAN / FACILITY INFORMATION

Physician Name_____ Contact Name _____ Contact Phone # _____

Address: _____City/State/Zip_____

DEA#:_____ NPI #:_____ State Lic #:_____ Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD-10 Code plus Description)

_____ Date of Diagnosis: _____

PRESCRIPTION ORDERS

DRUG 1	**DOSE**	**ROUTE**	**FREQUENCY**	**DURATION**

****HOLD IF HEMOGLOBIN IS GREATER THAN 11g/dl or PER PROVIDER, HOLD IF_____**

- **H&H WILL BE DRAWN AT THE HOSPITAL PRIOR TO EACH DOSE NEEDED**

INCLUDE COPIES OF THE FOLLOWING:

- **CBC MUST BE CHECKED WITHIN THE LAST 30 DAYS OTHERWISE HOSPITAL WILL COLLECT LABS PRIOR TO THE INJECTION**
- **H&P DATED WITHIN THE LAST 2 YEARS**

LABS

SELECT BELOW	LAB REQUESTED	FREQUENCY
	CBC w/ Diff	
	BMP	
	CMP	
	BUN/CREATININE	
	ESR	
	CRP	
	CPK	
	Other:	
	Other:	

NOTES/INSTRUCTIONS/OTHER

_____
_____
_____
_____
_____
_____
_____

Physician's Signature _____**Time**_____ **Date**_____

Revised 07/2022

Fax completed form to the MRMC Infusion Center at 979-241-5965.
PLEASE include copies of: H+P, OFFICE NOTES, LABS, ACTIVE MEDICATION PROFILE, and CURRENT INSURANCE INFORMATION in order for your referral to be processed.