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

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Physician's Signature ____**Time**____________________ **Date**______________

Reviewed 04/2026

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.