

# SAMSCA REFERRAL FORM

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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.	30	
	<input type="checkbox"/> 30mg Tablet	<input type="checkbox"/> Take _____ tablets by mouth once daily.	30-day supply	

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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It's as simple as caring.

Ph. 800-834-8778  
Fax 877-466-8040

E-Scribe Information:  
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