Kohll's RX SPECIALTY CARE

HYPERKALEMIA-NEPHROLOGY SPECIALTY CARE PROGRAM

Phone: **877-324-2501** • Fax: **888-972-4110**

KLOUDSCRIPT Community Led Specialty Pharmacy Care

1 PATIENT INFORMATION:

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Phone: _____ Alt. Phone: _____

Email: _____

DOB: _____ Gender: ❍ M ❍ F Caregiver: _____

Height: _____ Weight: _____ Allergies: _____

2 PRESCRIBER INFORMATION:

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Phone: _____ Fax: _____

NPI: _____ DEA: _____

Tax I.D.: _____

Office Contact: _____ Phone: _____

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Diagnostic Information

Date of Diagnosis: _____ ICD-10: _____

Other: _____

Is Patient taking Potassium supplements? ❑ Yes ❑ No

Is Patient taking ❑ ACE Inhibitor ❑ ARB

I understand Veltassa or Lokelma should not be used as emergency treatment for life-threatening Hyperkalemia. ❑ Yes

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

Labs

Serum Potassium: _____ Date: _____

Intact PTH Level: _____ Date: _____

Serum Creatinine: _____ Date: _____

Creatinine Clearance: _____ Date: _____

Medication List and Contraindications

Sodium Polystyrene Sulfonate: _____

Loop Diuretic: _____

Thiazide Diuretic: _____

Calcium: _____

Insulin: _____

Other: _____

4 INJECTION TRAINING:

❍ To Be Administered by Pharmacist ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

5 PICK UP OR DELIVERY:

❍ Delivery to Patient's Home ❍ Delivery to Physician's Office ❍ Pharmacy to Coordinate

6 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION INFORMATION: (Please be sure to choose both induction and maintenance dose where applicable)

Patient Name: _____ Patient's Date of Birth: _____

Medication	Dosage & Strength	Direction	QTY	Refills
❑ VELTASSA®	❑ 8.4G Powder for Oral Suspension ❑ 16.8G Powder for Oral Suspension ❑ 25.2G Powder for Oral Suspension	❑ _____ ❑ _____ ❑ _____		
❑ LOKELMA™	❑ 5G Powder for Oral Suspension ❑ 10G Powder for Oral Suspension	❑ _____ ❑ _____		
❑ OTHER	_____	_____		

PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ Date: _____ Signature: _____ Date: _____

Substitution Permitted **Dispense As Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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