



# Patient Referral/Medication Request – Heparin and Low Molecular Weight Heparins

**Aetna Specialty Pharmacy®**  
 503 Sunport Lane  
 Orlando, FL 32809  
**Phone:** 1-866-782-2779 (1-866-782-ASRX)  
**FAX:** 1-866-329-2779 (1-866-FAX-ASRX)

Today's Date: \_\_\_\_\_ Anticipated Start Date: \_\_\_\_\_

## PATIENT INFORMATION

First Name:		Last Name:	
Address:		City:	State: Zip:
Home Phone:		Work Phone:	Cell Phone:
DOB:	Height:	Weight:	Allergies:
Ship Meds to: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Doctor's Office			

## INSURANCE INFORMATION

<b>Primary Insurance:</b>		<b>Pharmacy Benefit Manager (PBM):</b>	
Policy #:	Group #:	Insured:	Phone:
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide #:		Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide #:	

<b>Secondary Insurance:</b>			
Policy #:	Group #:	Insured:	Phone:

## PHYSICIAN INFORMATION

First Name:		Last Name:		M.D./D.O.	
Address:		City:	State:	Zip:	
Phone:	Fax:	St Lic. #:	NPI #:	DEA #:	UPIN:
Office Contact Name:				Phone:	

## DIAGNOSIS:

<b>Primary:</b>	ICD 9:	<b>Secondary:</b>	ICD 9:
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## PRESCRIPTION (Please select from below and provide approximate days supply.)

<input type="checkbox"/> <b>Heparin Sod.</b> # of Refills _____ <input type="checkbox"/> 1,000 U/ml # of doses _____ <input type="checkbox"/> 5,000 U/ml # of doses _____ <input type="checkbox"/> 10,000 U/ml # of doses _____ <input type="checkbox"/> 20,000 U/ml # of doses _____  Directions: Inject _____ units. SQ _____ x _____ doses. (frequency)	<input type="checkbox"/> <b>Innohep</b> # of Refills _____ <input type="checkbox"/> 20,000IU/ml 2ml multidose vial # of vials _____  Directions: Inject _____ IU. SQ _____ x _____ doses. (frequency)
<input type="checkbox"/> <b>Lovenox</b> # of Refills _____ <input type="checkbox"/> 30mg/0.3ml prefilled syringe # of doses _____ <input type="checkbox"/> 30mg/0.3ml prefilled syringe # of doses _____ <input type="checkbox"/> 40mg/0.4ml prefilled syringe # of doses _____ <input type="checkbox"/> 60mg/0.6ml graduated PFS # of doses _____ <input type="checkbox"/> 80mg/0.8ml graduated PFS # of doses _____ <input type="checkbox"/> 100mg/1.0ml graduated PFS # of doses _____ <input type="checkbox"/> 120mg/0.8ml graduated PFS # of doses _____ <input type="checkbox"/> 150mg/1.0ml graduated PFS # of doses _____ <input type="checkbox"/> 100mg/1.0ml 3ml multidose vial # of vials _____  Directions: Inject _____ mg. SQ _____ x _____ doses. (frequency)	<input type="checkbox"/> <b>Arixtra</b> # of Refills _____ <input type="checkbox"/> 2.5mg/0.5ml prefilled syringe # of doses _____ <input type="checkbox"/> 5.0mg/0.4ml prefilled syringe # of doses _____ <input type="checkbox"/> 7.5mg/0.6ml prefilled syringe # of doses _____ <input type="checkbox"/> 10mg/0.8ml prefilled syringe # of doses _____  Directions: Inject _____ mg. SQ _____ x _____ doses. (frequency)
<input type="checkbox"/> <b>Fragmin</b> # of Refills _____ <input type="checkbox"/> 10,000IU/ml 9.5ml multidose vial # of vials _____ <input type="checkbox"/> 25,000IU/ml 3.8ml multidose vial # of vials _____ <input type="checkbox"/> 2,500IU/0.2ml prefilled syringe # of doses _____ <input type="checkbox"/> 5,000IU/0.2ml prefilled syringe # of doses _____ <input type="checkbox"/> 7,500IU/0.3ml prefilled syringe # of doses _____ <input type="checkbox"/> 10,000 U/1.0ml prefilled syringe # of doses _____  Directions: Inject _____ IU. SQ _____ x _____ doses. (frequency)	<h3>SUPPLIES</h3> <p>If medication is shipping to the patient's home, all appropriate supplies necessary to administer the medication will be included with the order.</p>

**Prescriber's Signature Required by Law:**

Interchange is mandated unless practitioner writes the words "NO SUBSTITUTION" in this space.  
 Incomplete information may result in therapy delay. Please complete all fields.