ALTEMIA® WRITTEN ORDER

Phone: 888-639-2110
eFax: 866-869-9442
Email: altemiaorders@pentechealth.com

Referral Date:
Clinic Contact:
Phone: **Email:**

To ensure timely processing, please complete and submit with insurance cards (front & back), LMN signed by prescriber, and recent clinical notes

Patient Detail

Name: Sex: ☐ M ☐ F DOB:
Parent or Legal Guardian, where applicable:
Address: City: State: Zip Code:
Phone: Email Address:
Allergies:
Egg Allergy: ☐Yes ■No Height: ☐ inches ☐cm Weight: ☐ lbs ☐kg
Emergency Contact Name: Relationship: Phone:
SCD health events in the last year: VOCs (#): Hospitalizations (#):

Insurance Detail

☐ Information attached (including front & back of insurance cards)

Primary Plan Name: Subscriber Name: DOB:
ID #: Group #: Phone:
Secondary Plan Name: Subscriber Name: DOB:
ID #: Group #: Phone:

Prescriber Detail

Prescriber Name: NPI: License #:
Preferred Communication Method: ☐ Phone ☐ Fax ☐ Email
Address:
Phone: Fax: Email:

Order

ICD-10 / Diagnosis Description (select):

☐ D57.1: Sickle-cell disease without crisis
☐ Other:

ALTEMIA Medical Food - supply as directed x 1 year

Select One:

	Patient Weight	Product	Directions	Boxes per Month
☐	<50kg	ALTEMIA - 30 x 5GM Packets	**1/2 packet by mouth daily**	**1**
☐	50kg – 90kg	ALTEMIA - 30 x 5GM Packets	**1 packet by mouth daily**	**1**
☐	>90kg	ALTEMIA - 30 x 5GM Packets	**2 packets by mouth daily**	**2**

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment. Pentec Health may contact this patient for purposes of completing the referral process.

Prescriber Signature: **Date:**