Insurance Verification

Name: Konefal, Walter DOB: 4/10/31 MR# 7295
Ins. ID # Aetna MEBLGJ9N (AP)
Phone#: 800 624-0756
Date: 9/19/17 Time: 3:02 DX: D[illegible]81, N18.3, D63.1
Eff Date: 1/1/17
Copay: 0 DED: 0
Percent: 100% OOP: 3400 - (472.25)
Name of Person: Anna
REF: 340222064B
Jcode: Aranesp - J0881
96372 - $15.00

Auth Req'd YES: X NO:
Auth# Date Span:
Phone: 866-503-0857. Fax:
Name: Chris

Can we Buy and Bill:
YES: NO:
Specialty Pharmacy:
Phone#: Fax:

If Stacy is not Here, You MUST Fax to Charlotte

OUTPATIENT INFUSION CENTER
ORANGE REGIONAL MEDICAL CENTER
NEW PATIENT INTAKE FORM
(MUST BE USED EVERYTIME A NEW PATIENT IS BOOKED)

NAME: Walter Konpal

DOB: 4/10/31

PT'S PHONE #:

PROCEDURE: Aranesp

DATE OF PROC: To be determined

DURATION: weekly

DIAGNOSIS: Kidney Disease

NAME OF PERSON TALKED TOO: Via Fax

PHYSICIAN & PHONE: Ramaswamy

INSURANCE:

ALLERGIES:

IMMEDIATELY AFTER MAKING THE APPOINTMENT,
FAX THIS FORM AND COPY OF THE SCRIPT FOR
AUTHORIZATION AND PRE REGISTRATION PROCESS.

STACY BUDD:
PHONE: (845) 333-1482
Fax: (845) 333-1715

CHARLOTTE:
PHONE: (845) 294-9708 X 296
Fax: (845)294-8340

aetna®

Erythropoiesis Stimulating Agents Injectable Medication Precertification Request

Page 1 of 2

(All fields must be completed and legible for precertification review)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date 9/19/17
☐ Continuation of therapy: Date of last treatment ___/___/___

Precertification Requested By: S. Budd Phone 845-333-1905 Fax: 845-333-1902

A. PATIENT INFORMATION

First Name: Walter	Last Name: Konefal		DOB: 4/10/31
Address: 174 Konefal Ave.	City: Pine Bush		State: NY ZIP: 12566
Home Phone: 845-744-2159	Work Phone:	Cell Phone:	Email:
Current Weight: 104 lbs or ___ kgs	Height: 68 inches or ___ cms	Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: MEB116J9N	Does patient have other coverage? ☐ Yes ☒ No
Group #:	If yes, provide ID#: ___ Carrier Name: ___
Insured:	Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name: Kavi	Last Name: Kamaswamy	Check One: ☒ M.D. ☐ D.O. ☐ N.P. ☐ P.A.	
Address: 111 Maltese Dr.	City: Middletown	State: NY	ZIP: 10940
Phone: 845-342-4774 Fax: 845-343-8741	St Lic #:	NPI #: 1922118215 DEA #:	UPIN:
Provider Email:	Office Contact Name:	Phone:	

Specialty *(Check one)*: ☒ Nephrologist ☐ Oncologist ☐ Other:

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☒ Outpatient Infusion Center Phone: 845-333-1905
Center Name: Orange Reg. Med. Ctr.
☐ Home Infusion Center Phone: ___
Agency Name: ___
☒ Administration code(s) (CPT): 96372 J0881

Dispensing Provider/Pharmacy: *(Patient selected choice)*
☐ *Outpatient Dialysis Center*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☒ Other: Hospital
Name Orange Reg. Med. Ctr.
Phone: 845 333 1905 Fax: 845 333-1902
TIN: 141364536 PIN: 1609875772

E. PRODUCT INFORMATION

Request is for: ☒ **Aranesp** ☐ **Epogen** ☐ **Mircera** ☐ **Procrit**

Dose/Frequency: ___
(Failure to provide dose & frequency may delay request)

F. OUTPATIENT DIALYSIS

Requesting Outpatient Dialysis Treatment? ☐ Yes ☒ No *If Yes,* ***CPT Code is:*** ☐ *90935* ☐ *90937* ☐ *90999* ☐ *Other* ___

G. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: D63.1 Secondary ICD Code: N18.3 Other ICD Code: ___

H. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For All Requests: (please note, unanswered questions may delay request):
Hemoglobin (Hgb) result? 9.1 mg/dL Date of test 8/23/17
☐ Yes ☐ No Is the patient currently taking iron supplements?

For Initial Requests:
☒ Yes ☐ No Does the patient experience shortness of breath, weakness, fatigue, or lightheadedness from anemia?
→ If yes, please indicate which of the following symptoms the patient experiences: ☐ shortness of breath ☐ weakness ☒ fatigue ☐ lightheadedness
☒ Yes ☐ No Are any of the above symptoms affecting the patient's ability to perform activities of daily living?
☐ Yes ☒ No Does the patient exhibit angina, syncope, or tachycardia from anemia?
→ If yes, please indicate which of the following symptoms of anemia the patient exhibits: ☐ angina ☐ syncope ☐ tachycardia

Which of the following laboratory test(s) has the patient had within the past 12 months? (please note, unanswered questions may delay response time)
Check all that apply and supply date and results.
☐ Iron Stores from Bone Marrow Iron - Date of test ___/___/___ Please indicate the result: ___ng/mL
☐ Serum Ferritin Levels - Date of test 8/15/17 Please indicate the result: 119 ng/mL
☐ Serum Transferrin Saturation (TSAT) - Date of test ___/___/___ Please indicate the result: ___%

Please choose from one of the indications below:
☐ **Anemia of Prematurity:** (6 week authorization)
Please indicate the patient's birth weight in grams: ___
Please indicate the patient's gestational age in weeks: ___

Continued on next page

This is for Buy + Bill

aetna®

Erythropoiesis Stimulating Agents Injectable Medication Precertification Request

(All fields must be completed and legible for precertification review)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Patient First Name	Patient Last Name	Patient Phone	Patient DOB

H. CLINICAL INFORMATION *(CONTINUED)* – Required clinical information must be completed in its entirety for all precertification requests.

☐ **Hepatitis C with Chemotherapy Induced Anemia:** (8 week authorization)
- ☐ Yes ☐ No Is the patient receiving interferon or pegylated interferon plus ribavirin?
- ☐ Yes ☐ No Is the patient's Hgb less than10 g/dL despite a reduction in the dose of ribavirin?

☒ **Chronic Kidney Disease (CKD / ESRD) Induced Anemia:** (16 week authorization)
- ☐ Yes ☒ No Is the patient currently receiving dialysis?
  - → Please indicate the patient's creatinine clearance: 1.35 mL/min Date of test 8/18/17
  - Please indicate the patient's glomerular filtration: _____mL/min/1.73m² Date of test ___/___/___
  - ☐ Yes ☐ No ☐ N/A Based on the decline rate of Hgb levels is there a likelihood of red blood cell transfusion?
  - ☐ Yes ☐ No Will this request be used to reduce the risk of alloimmunization and/or other RBC transfusion-related risks?
- ☐ Yes ☐ No Is this a continuation request for a member currently on dialysis?
  - → *Check all that apply:* ☐ acute myocardial infarction (AMI) ☐ orthostatic hypotension ☐ living at an elevation of greater than 5000ft ☐ angina ☐ anemia with Hgb less than 11g/dL has significantly interfered with activities of daily living

☐ **Antineoplastic / Myelosuppressive Chemotherapy Induced Anemia:** (8 week authorization)
solid tumors, multiple myeloma, lymphoma, lymphocytic leukemia)
- ☐ Yes ☐ No Is the patient actively receiving chemotherapy?
  - → Date of most recent chemotherapy treatment ___/___/___
- ☐ Yes ☐ No Is the intent of the treatment to be curative?
- ☐ Yes ☐ No Is the patient participating in the REMS program?
- ☐ Yes ☐ No Is the planned chemotherapy treatment regimen to continue for a minimum of 2 months?

Continuation of treatment:
- ☐ Yes ☐ No Has there been a decrease in the need for transfusions in patients who are receiving chemotherapy?

☐ **Human Immunodeficiency Virus (HIV) Disease Induced Anemia:** (8 week authorization)
Endogenous EPO level: _____mIU/mL Date of test ___/___/___
- ☐ Yes ☐ No Is the patient currently receiving zidovudine?
- ☐ Yes ☐ No Is the current zidovudine dose less than or equal to 4200 mg/week?

☐ **Myelodysplastic Syndrome Induced Anemia:** (12 week authorization)
- ☐ Endogenous serum erythropoietin (EPO) levels are less than or equal to 500 IU/L.
  - → Endogenous EPO level: _____mIU/mL Date of test ___/___/___
- ☐ Yes ☐ No Does the bone marrow have less than 15% blasts?
- ☐ Yes ☐ No Has the patient required a blood transfusion of 2 or fewer units of blood per month?
- ☐ Yes ☐ No Does the patient have a lower risk myelodysplastic syndrome?
  - → If yes, ☐ Yes ☐ No Is there clinical evidence that the patient has del 5q (part of chromosome 5 missing)?

For Continuation of Therapy:
- ☐ Yes ☐ No Have the transfusion requirements been reduced by less than 50% after 6 months of therapy?

☐ **Miscellaneous Induced Anemias:** (8 week authorization)
Check all that apply and supply requested information:
- ☐ The underlying chronic disease has been identified. → Please identify the underlying chronic disease: _____
- ☐ The patient cannot or will not receive whole blood or components as replacement for traumatic/surgical blood loss.
- ☐ The patient is scheduled to undergo high-risk surgery. → Is there an increased risk of or intolerance to blood transfusions? ☐ Yes ☐ No
  - → Date of surgery ___/___/___ Type of surgery: _____

Continuation of Treatment: (please complete for ALL continuation requests)
- ☐ Yes ☐ No Has the patient's hemoglobin (Hgb) risen by at least 1 g/dL while on erythropoietin stimulating treatment?
  - → ***If no,*** *please supply rationale for continuation of treatment request.* _____
  - → ***If yes,*** *please* indicate the pre-treatment hemoglobin level: _____g/dL Date obtained: ___/___/___

I. ACKNOWLEDGEMENT

Request Completed By *(Signature Required)*: S. K **Date:** 9/20/17

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.

ORANGE REGIONAL MEDICAL CENTER
Physician Order Form

KONEFAL, WALTER
DOB 4/10/31.
Patient Label

DO NOT USE ABBREVIATIONS:

U	MS	MSO_4	$MgSO_4$	QD	µg
IU	SC	SQ	SL	QOD	

OUTPATIENT DARBEPOETIN (Aranesp®) Erythropoetic Stimulating Agent (ESA) Order Form

Initial Hemoglobin (Hgb)/Hematocrit (Hct) Date/level:_____ Wt: _____ kg
Current Hgb:_____ Hct: _____

DIAGNOSIS (Check one):

☐ **Chemotherapy induced anemia**
Hemoglobin (Hgb)/ Hematocrit (Hct) must be < 10 g/dL and < 30%
Darbepoetin initial dose ≤ 2.25 mcg/kg/week
On week 4 dose may be increased by 25% if Hgb/Hct rise is < 1/3.
By week 8 discontinue treatment unless a rise of 1/3 is documented

Hold Aranesp for Hgb ≥ 11 gm%

☒ **Chronic Kidney Disease(CRD) not on dialysis**
For chronic kidney disease creatinine ≥ 3 and CrCl < 60 mL/min
Monitor to ensure transferring saturation > 20% and/or serum ferritin > 100 ng/mL

☐ **End Stage Renal Disease(ESRD) on dialysis**
Monitor to ensure transferring saturation > 20% and/or serum ferritin > 100 ng/mL

☐ **HIV/AIDS anemia induced by zidovudine or other nucleoside reverse transcriptase inhibitors**

☐ **Anemia related to myelodysplastic syndrome (MDS) excluding AML and CML**
Bone marrow biopsy < 6% blasts
Erythropoietin level 100 or less
After 2 months of treatment consider discontinuing if there is no significant increase in Hgb/Hct and/or decreased transfusions

☐ **Treatment of anemia of selected chronic diseases (check one below)**
- ☐ Rheumatoid arthritis,
- ☐ Systemic lupus erythematosus
- ☐ Inflammatory bowel diseases
- ☐ Hepatitis C undergoing treatment

Initial Hgb/Hct must be < 10 g/dL and < 30%. For all uses other than chemotherapy induced anemia, titrate dose of darbepoetin to maintain a target Hgb of 10-12 g/dL and Hct of 30-36% by appropriate timed dose adjustment.

Date of last ESA agent: _____ Do not give Darbepoetin more frequently than once weekly

Drug	Dose (mcg)	Route	Frequency	RN/Time
Darbepoetin (Aranesp®)	40 mcg	☒ SubQ ☐ IV	weekly	

Print Last Name RAMASWAMY
Physician Signature [signature]
Date 9/14/17 Time: 2:30pm

Print Last Name:_____
Nurse Signature:_____ Date:_____
RBV INIT____Time:_____ Faxed ☐ Time Faxed _____

Progress note

Patient: Konefal, Walter J
Account Number: 97364
DOB: 04/10/1931 **Age:** 86 Y **Sex:** Male
Phone: 845-744-2159
Address: 174 KONEFAL AVE, PINE BUSH, NY-12566-6207
Pcp: RAJAN GULATI

Provider: Ravi Ramaswamy, MD
Date: 09/18/2017

Subjective:

Chief Complaints:
1. HFU.

HPI:
-Today's Visit: ;
86 year old male with a history of chronic kidney disease stage III, ASHD, hypertension who was recently in hospital with pain in the left foot which was treated as cellulitis and later also for possible gout. He improved with treatment and his renal functions have been stable. He has loss of appetite and loss of weight. He is here today accompanied by his daughter. He has no other complaints of dyspnea or chest pain. He has pain in his left foot and recently saw the rheumatologist who gave him an injection in the ankle and told him he had bursitis of the ankle. He complains of fatigue.

ROS:
HEENT:
Patient denies vertigo, tinnitus, epistaxis.
Respiratory:
Patient denies cough, shortness of breath at rest, wheezing, orthopnea, dyspnea.
Cardiovascular:
Patient denies chest pain, palpitations.
Gastrointestinal:
Patient complaining of poor appetite. Says he feels satiated after a few bites of food. Patient denies abdominal pain, nausea, vomiting, diarrhea, constipation.
Genitourinary:
Patient denies burning on urination, frequent urination, difficulty urinating, blood in the urine.

Musculoskeletal:
Patient complaining of pain in left ankle, weakness and needs a walker. Fatigue and unable to do much though he has been active all along. .
Neurologic:
Patient denies headache, dizziness, fainting,vertigo, ringing in the ears, weakness, tingling/numbness, siezures..
Psychiatric:
Patient denies anxiety, insomnia. Comments daughter feels the father is depressed.

Medical History: Atherosclerotic heart disease of native coronary artery without angina pectoris, Heart failure, unspecified, Essential (primary) hypertension, Unspecified dementia without behavioral disturbance, A.fib.

Surgical History: HIP REPLACEMENT; lt , Prostatectomy 2003, Stents (2) Coronary 2005.

Hospitalization/Major Diagnostic Procedure: ORMC INFECTION 07/2017, ankle sweeling, pain- arthritic gout 08/29/2017.

Family History: Migrated Family Hx: Brother: Cancer; leukemia ; Mother: Heart Disease ; .

Social History:
Tobacco Use:
Tobacco Use/Smoking
Additional Findings: Tobacco Non-User *Current non-smoker*
Exposure to second hand smoke?: declines.

Medications: Taking Coumadin 2 MG Tablet 1 Once a Day for 30 Days Orally , Taking Metoprolol Succinate ER 200 MG metoprolol succinate oral tablet extended release 24 hr , Taking Digoxin 125 MCG Tablet 1 tablet

Orally every other day, Taking Furosemide 20 MG Tablet 1 tablet Orally Once a day, Taking Metolazone 5 MG Tablet 1 tablet Orally Once a day, Taking Spironolactone 50 MG Tablet 1 tablet Orally Once a day, Not-Taking/PRN Colchicine 0.6 MG Tablet 1 tablet Orally Once a day, Notes: started in the hospital, Not-Taking/PRN Zantac 150 MG Tablet 1 tablet Orally twice daily, Not-Taking/PRN Allopurinol 100 MG Tablet 1 tablet Orally Once a day, Not-Taking/PRN PredniSONE 10 MG Tablet 1 tablet Orally 3 tabs x 2 days 2 tabs x 2 days 1 tab x 2 days 1/2 tab x 4 days take with food, Medication List reviewed and reconciled with the patient

Allergies: Penicillins: anaphylaxis: Allergy, Vicodin: anaphylaxis: Allergy, Zocor: anaphylaxis: Allergy, Doxycycline: anaphylaxis: Allergy.

Objective:

Vitals: BP 128/62 mm Hg, HR 76 /min, RR 16 /min, Ht 68 in, Wt 104 lbs, BMI 15.81 Index, Oxygen sat % 95, Wt-kg 47.17 kg.

Examination:

General Examination:

GENERAL APPEARANCE: alert, pleasant, well nourished, in no acute distress..
HEAD: atraumatic, normocephalic.
EYES: pupils equal, round, reactive to light and accommodation, extraocular movement intact (EOMI), conjunctiva clear, sclera non-icteric.
THROAT: no erythema, no exudate.
NECK/THYROID: neck supple, full range of motion.
LYMPH NODES: no cervical adenopathy.
HEART: regular rate and rhythm, S1, S2 normal.
LUNGS: good air movement, clear to auscultation bilaterally, no respiratory distress.
ABDOMEN: soft, nontender, flat.
EXTREMITIES: no clubbing, cyanosis, or edema noted,.
SKIN: normal inspection, no rashes, warm and dry.

Assessment:

Assessment:

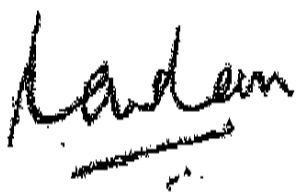
1. CKD (chronic kidney disease) stage 3, GFR 30-59 ml/min - N18.3 (Primary)
2. Psoriatic arthritis - L40.50
3. Acute kidney failure, unspecified - N17.9
4. Chronic congestive heart failure, unspecified congestive heart failure type - I50.9
5. Psoriasis - L40.9
6. Anemia, unspecified type - D64.9
7. Other iron deficiency anemia - D50.8

Discussed with patient and daughter that he will need Venofer and Aranesp at ORMC outpatient infusion center .To check labs at outpatient infusion.

Plan:

Follow Up: 3 Months

Provider: Ravi Ramaswamy, MD
Patient: Konefal, Walter J **DOB:** 04/10/1931 **Date:** 09/18/2017



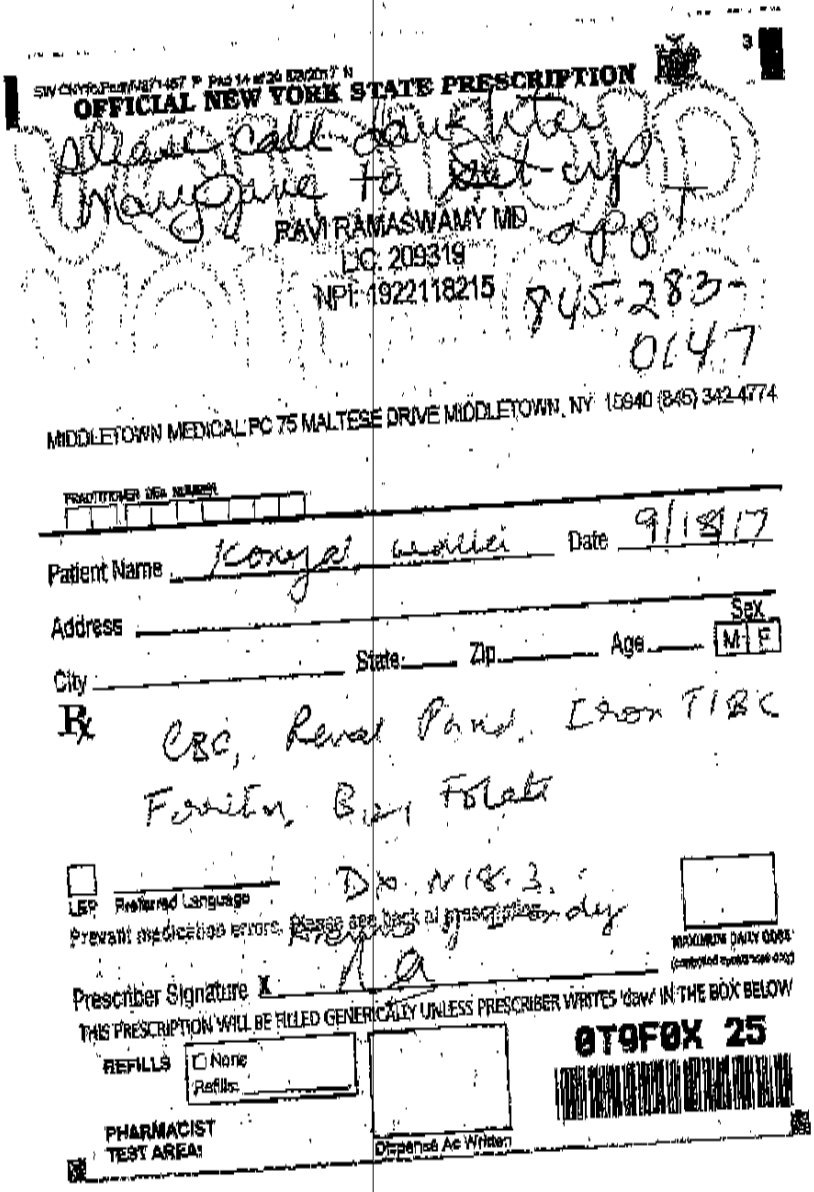
Electronically signed by RAVI RAMASWAMY , MD on 09/18/2017 at 03:29 PM EDT
Sign off status: Completed

KONEFAL, WALTER J (MRN 72995)

	21 8/14/2017 0744	20 8/14/2017 1442	19 8/15/2017 0720	18 8/15/2017 1046	17 8/16/2017 0715	16 8/17/2017 0725	15 8/17/2017 0850	14 8/18/2017 0740
HEMOGLOBIN	9.3		9.6		9.5			9.4
Hematocrit	29.0		29.3		29.8			29.5
MCV	80.6		80.7		81.6			81.5
MCH, POC	25.8		26.4		26.0			26.0
MCHC	32.1		32.8		31.9			31.9
RDW	17.3 ▲		17.3 ▲		17.3 ▲			17.4 ▲
Platelets	193		214		235			293
COAGULATION								
Protime		20.8 * ▲		24.7 * ▲	28.7 * ▲	39.8 * ▲		46.5 * ▲
INR		1.79 * ▲		2.12 * ▲	2.45 * ▲	3.36 * ▲		3.91 * ▲
INR UNDILUTED 0 HR								
INR 1:1 0 HR								
INR 1:1 1 HR								
INR 1:1 2 HR								
GENERAL CHEMISTRY								
Sodium	134		133		134		132	135
Potassium	3.8		3.6		3.8		4.0	3.2
Chloride	98		96		98		97	96
CO2	29		30		30		28	30
BUN	33 ▲		34 ▲		36 ▲		42 ▲	41 ▲
Glucose	91		99		92		142 ▲	92
CALCIUM	8.1		8.3		8.3		8.3	8.3
Creatinine, Ser	1.32 ▲		1.29 ▲		1.38 ▲		1.38 ▲	1.35 ▲
Total Bilirubin								
ALBUMIN			2.3		2.2		2.5	
Total Protein								
Alkaline Phosphatase								
AST								
ALT								
Anion Gap	7		7		6		7	9
eGFR AFRICAN AMERICAN	>60.0		>60.0		59.1		59.1	>60.0
eGFR NON AFRICAN A...	51.4		52.8		48.9		48.9	50.1
Iron			16					
TIBC			295					
Iron Saturation			5					
Magnesium							2.2	
Phosphorus			3.3		3.4			
CARDIAC MARKERS								
Total CK								

	21 8/14/2017 0744	20 8/14/2017 1442	19 8/15/2017 0720	18 8/15/2017 1046	17 8/16/2017 0715	16 8/17/2017 0725	15 8/17/2017 0850	14 8/18/2017 0740
Troponin I								
THERAPEUTIC DRUGS								
Vancomycin Tr								
SPECIAL CHEMISTRY								
Ferritin			*119*					
EKG								
EKG 12-LEAD								
Ventricular Rate								
Atrial Rate								
P-R Interval								
QRS Duration								
Q-T Interval								
QTC Calculation (B...								
P Axis								
R Axis								
T Axis								
OTHERS								
Diastolic Blood Pr...								
Systolic Blood Pre...								

	13 8/19/2017 0751	12 8/19/2017 0752	11 8/19/2017 1428	10 8/20/2017 0741	9 8/20/2017 1018	8 8/20/2017 1027	7 8/20/2017 1637	6 8/20/2017 2210
AUTOMATED HEMATOLOGY								
WBC	11.5							
RBC	3.68							
HEMOGLOBIN	9.9 ▼							
Hematocrit	30.4 ▼							
MCV	82.6							
MCH, POC	26.9							
MCHC	32.6							
RDW	17.7 ▲							
Platelets	325							
COAGULATION								
Protime			38.5 * ▲	34.3 * ▲				
INR			3.26 * ▲	2.91 * ▲				
INR UNDILUTED 0 HR	3.36 ▲			2.81 ▲				
INR 1:1 0 HR	1.32			1.36				
INR 1:1 1 HR	1.30			1.33				
INR 1:1 2 HR	1.30			1.35				
GENERAL CHEMISTRY								
Sodium		136						
Potassium		3.8						
Chloride		97 ▼						
CO2		33 ▲						
BUN		43 ▲						
Glucose		86						
CALCIUM		8.5						
Creatinine, Ser		1.33 ▲						
Total Bilirubin								
ALBUMIN								
Total Protein								
Alkaline Phosphatase								
AST								
ALT								
Anion Gap		6 ▼						
eGFR AFRICAN AMERICAN		>60.0						
eGFR NON AFRICAN A...		51.0 ▼						
Iron								
TIBC								
Iron Saturation								
Magnesium								



OFFICIAL NEW YORK STATE PRESCRIPTION

Please call daughter Morgane to set up appt

RAVI RAMASWAMY MD
LIC. 209319
NPI 1922118215

845-283-0147

MIDDLETOWN MEDICAL PC 75 MALTESE DRIVE MIDDLETOWN, NY 10940 (845) 342-4774

PRACTITIONER DEA NUMBER

Patient Name Konyei Date 9/18/17

Address Sex M F

City State: Zip Age

Rx CBC, Renal Panel, Iron TIBC
Ferritin, B12, Folate

Dx: N18.3

LEP Preferred Language

Prevent medication errors. Please see back of prescription duly

MAXIMUM DAILY DOSE (optional)

Prescriber Signature X

THIS PRESCRIPTION WILL BE FILLED GENERICALLY UNLESS PRESCRIBER WRITES 'DAW' IN THE BOX BELOW

REFILLS ☐ None Refills:

PHARMACIST TEST AREA:

Dispense As Written

0T9F0X 25

OUTPATIENT INFUSION CENTER
ORANGE REGIONAL MEDICAL CENTER
NEW PATIENT INTAKE FORM
(MUST BE USED EVERYTOME A NEW PATIENT IS TO BE SCHEDULED)

NAME: Walter Kondas

DOB: 4/10/31

PT'S PHONE #: 744-2159

PROCEDURE: labwork Darbepoetin + Aranesp

DURATION: 1hr

DIAGNOSIS: Chronic Kidney disease

NAME OF PERSON TALKED TOO: 342-4774

PHYSIAN & PHONE: Dr. Ramaswamy

INSURANCE:

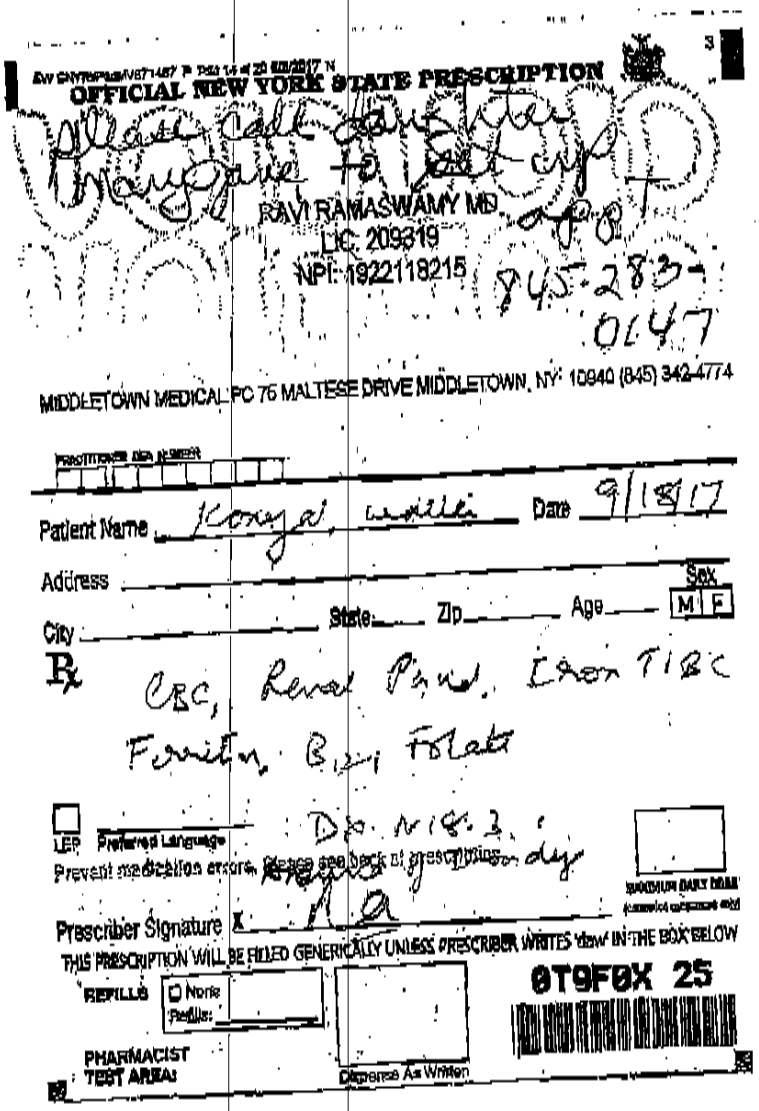
ALLERGIES:

IMMEDIATELY AFTER MAKING THE APPOINTMENT, FAX THIS FORM AND COPY OF SCRIPT FOR AUTHORIZATION AND PRE-REGISTRATION PROCESS: **EXT 1715**

*PLEASE SEND A COPY TO PHARMACY IF PATIENT IS TO RECEIVE CHEMOTHERAPY: **EXT 1124**

STACY BUDD
PHONE: (845) 333-1905
FAX: (845) 333-1902

ALLISON ROCHE
PHONE: (845) 333-1906
FAX: (845) 333-1902



OFFICIAL NEW YORK STATE PRESCRIPTION

Please call patient to let us know

RAVI RAMASWAMY MD
LIC. 209319
NPI: 1922118215

845-283-0147

MIDDLETOWN MEDICAL PC 75 MALTESE DRIVE MIDDLETOWN, NY 10940 (845) 342-4774

Patient Name Kenya Wells Date 9/18/17

Address Sex M F

City State Zip Age

Rx CBC, Renal Panel, Iron TIBC
Ferritin, B12, Folate

Dx. M18.3

LEP Preferred Language

Prevent medication errors. Please see back of prescription. dgr

MAXIMUM DAILY DOSE

Prescriber Signature X

THIS PRESCRIPTION WILL BE FILLED GENERICALLY UNLESS PRESCRIBER WRITES 'daw' IN THE BOX BELOW

REFILLS None Refills:

0T9F0X 25

PHARMACIST TEST AREA:

Dispense As Written

ORANGE REGIONAL MEDICAL CENTER
Physician Order Form

KONEPAL, WALTER
DOB 4/10/31.
Patient Label

DO NOT USE ABBREVIATIONS:

U	MS	MSO_4	$MgSO_4$	QD	µg
IU	SC	SQ	SL	QOD	

OUTPATIENT DARBEPOETIN (Aranesp®) Erythropoetic Stimulating Agent (ESA) Order Form

Initial Hemoglobin (Hgb)/Hematocrit (Hct) Date/level:_____ Wt: _____ kg
Current Hgb:_____ Hct: _____

DIAGNOSIS (Check one):

☐ **Chemotherapy induced anemia**
Hemoglobin (Hgb)/ Hematocrit (Hct) must be < 10 g/dL and < 30%
Darbepoetin initial dose ≤ 2.25 mcg/kg/week
On week 4 dose may be increased by 25% if Hgb/Hct rise is < 1/3.
By week 8 discontinue treatment unless a rise of 1/3 is documented

☒ **Chronic Kidney Disease(CRD) not on dialysis**
For chronic kidney disease creatinine ≥ 3 and CrCl < 60 mL/min
Monitor to ensure transferring saturation > 20% and/or serum ferritin > 100 ng/mL

Hold Aranesp for Hgb ≥ 11 gm%

☐ **End Stage Renal Disease(ESRD) on dialysis**
Monitor to ensure transferring saturation > 20% and/or serum ferritin > 100 ng/mL

☐ **HIV/AIDS anemia induced by zidovudine or other nucleoside reverse transcriptase inhibitors**

☐ **Anemia related to myelodysplastic syndrome (MDS) excluding AML and CML**
Bone marrow biopsy < 5% blasts
Erythropoietin level 100 or less
After 2 months of treatment consider discontinuing if there is no significant increase in Hgb/Hct and/or decreased transfusions

☐ **Treatment of anemia of selected chronic diseases (check one below)**
- ☐ Rheumatoid arthritis,
- ☐ Systemic lupus erythematosus
- ☐ Inflammatory bowel diseases
- ☐ Hepatitis C undergoing treatment

Initial Hgb/Hct must be < 10 g/dL and < 30%. For all uses other than chemotherapy induced anemia, titrate dose of darbepoetin to maintain a target Hgb of 10-12 g/dL and Hct of 30-36% by appropriate timed dose adjustment.

Date of last ESA agent: _____ Do not give Darbepoetin more frequently than once weekly

Drug	Dose (mcg)	Route	Frequency	RN/Time
Darbepoetin (Aranesp®)	40 mcg	☒ SubQ ☐ IV	weekly	

Print Last Name KANAN SINGH
Physician Signature
Date 9/19/17 Time: 3:30pm

Print Last Name:
Nurse Signature: Date:
RBV INIT Time: Faxed ☐ Time Faxed

Physician Orders/Outpatient darbepoetin order form/Pharmacy/3-11

* * * Communication Result Report (Sep. 19. 2017 3:54PM) * * *

1)
2)

Date/Time: Sep. 19. 2017 3:52PM

File No.	Mode	Destination	Pg(s)	Result	Page Not Sent
7876	Memory TX	863423593	P. 3	OK	

Walter Konefal

Reason for error
E. 1) Hang up or line fail
E. 2) Busy
E. 3) No answer
E. 4) No facsimile connection
E. 5) Exceeded max. E-mail size
E. 6) Destination does not support IP-Fax

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707 Main Street
Middletown, NY 10940
845-333-1905
845-333-1902 Fax

ORANGE REGIONAL MEDICAL CENTER

Fax

To: From: S. Budd

Fax: 845-342-2893 Pages: 3

Phone: Date: 9/19/17

Re: cc:

Urgent For Review Please Comment Please Reply Please Recycle

4 comments:

Could you run for Monique
Stacy

Stacy Budd
OP INFUSION CENTER
845-333-1905
845-333-1902 Fax#

707 Main Street
Middletown, NY 10940
845-333-1905
845-333-1902 Fax

ORMC ORANGE REGIONAL MEDICAL CENTER

Fax

To: **From:** S. Budd

Fax: 845-342-3593 **Pages:** 3

Phone: **Date:** 9/19/17

Re: **cc:**

Urgent For Review **Please Comment** X **Please Reply** ☐ **Please Recycle**

- **Comments:**

auth form for Aranesp.

Stacy

Stacy Budd
OP INFUSION CENTER
845-333-1905
845-333-1902 Fax#

aetna℠

Fax Message

To: ATTN STACY

Fax: 8453331902

From:

Date: Tuesday, September 19, 2017 3:20:28 PM
Pages (including this page): 03
Subject: FAX#844-268-7263

PLEASE INDICATE BUY AND BILL

* * * Communication Result Report (Sep. 20. 2017 10:19AM) * * *

1)
2)

Date/Time: Sep. 20. 2017 10:14AM

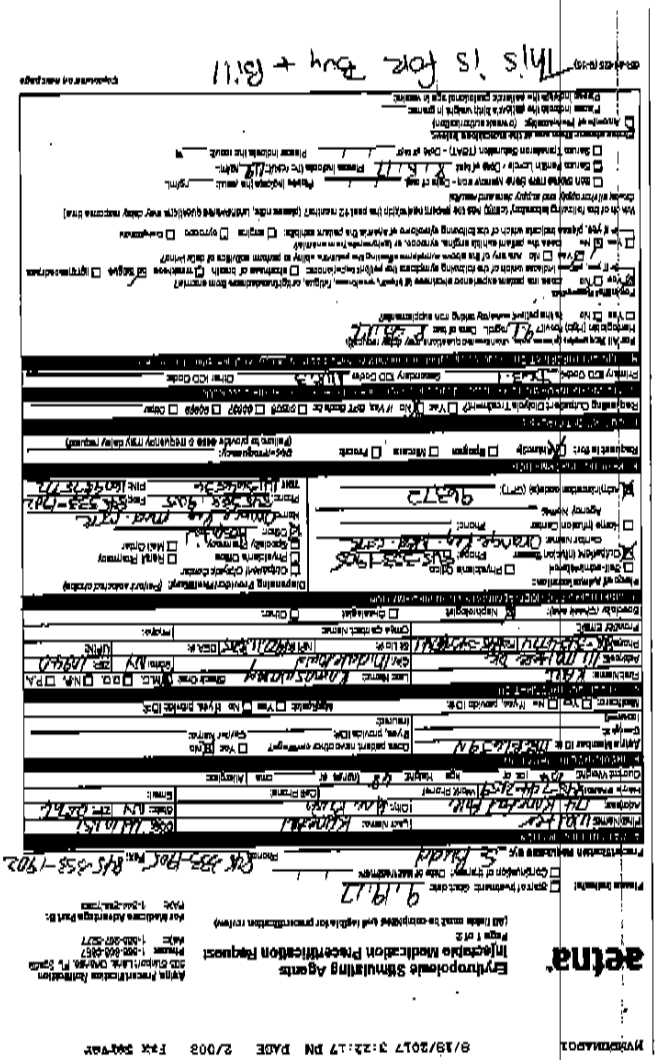
File No., Mode	Destination	Pg(s)	Result	Page Not Sent
7916 Memory TX	8618442687263	P. 9	OK	

Maryane 845-283-0947 daughter.

Konefal, Walter

Reason for error
E. 1) Hang up or line fail
E. 2) Busy
E. 3) No answer
E. 4) No facsimile connection
E. 5) Exceeded max. E-mail size
E. 6) Destination does not support IF-Fax

* This was not worked on.



aetna®

To: ORANGE REGIONAL MEDICAL CENTER
Fax Number: 8453331902
From:
Voice Number:
Date: Tuesday, September 26, 2017 10:59:16 AM
Pages (including this page) : 06

Memo:

Subject: FAX - <<TOPIC_ID:162732796>><<LTR_ID>>:11964294
From Fax:
From Company: Aetna

Note: If you do not receive all referenced pages or if you received this transmission in error, please notify us immediately.

148191872WC

PARTE GENRAL APPR - <<TOPIC_ID:162732796>>

aetna®

Aetna Life Insurance Company
Attn: Thomas Keefe
2222 Ewing Road
Moon Township PA 15108

September 26, 2017

WALTER KONEFAL
174 KONEFAL AVENUE
PINE BUSH NY 12566

We authorized your service(s)

RE: WALTER KONEFAL
Auth #: 3145166900000
Provider Name: ORANGE REGIONAL MEDICAL CENTER
From Date: 09/20/2017

ID#: MEBL6J9N

To Date: 01/10/2018

Aetna Life Insurance Company got your request to review the following service(s). We are pleased to tell you that we approved the service(s) and you can now make arrangements.

Aranesp, a treatment for low blood count

If you need other services, Aetna Life Insurance Company will have to authorize or precertify them first. You or your doctor will need to call us. Our phone number is on your member ID card. The TTY number for the hearing impaired is **711**, and help is available from 8 a.m. to 8 p.m., Monday through Friday. If you have questions about this authorization or your benefits, call the same phone number on your ID card. (TTY **711**).

Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Our SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premium and/or co-payments/co-insurance may change on January 1 of each year. See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Aetna Life Insurance Company

cc: ORANGE REGIONAL MEDICAL CENTER

We comply with applicable Federal civil rights laws and do not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability. We provide free aids/services to people with disabilities and to people who need language assistance. If you need a qualified interpreter, written information in other formats, translation or other services, contact the phone number on your member identification card. If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can file a grievance in writing with our Grievance Department (write to the address listed in your Evidence of Coverage) or by phone by calling the phone number on your member identification card (TTY: 711). You can also file a grievance by contacting our Civil Rights Coordinator by phone at 1-855-348-1369, by email at MedicareCRCoordinator@aetna.com. You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-868-1019, 800-537-7697 (TDD).

TTY: 711

If you speak a language other than English, free language assistance services are available. Visit our website or call the phone number on your member identification card. (English)

Si habla un idioma que no sea inglés, se encuentran disponibles servicios gratuitos de asistencia de idiomas. Visite nuestro sitio web o llame al número de teléfono que figura en su tarjeta de identificación de miembro. (Spanish)

如果您使用英文以外的語言，我們將提供免費的語言協助服務。請瀏覽我們的網站或撥打您會員卡上的電話號碼。(Traditional Chinese)

Если вы не владеете английским и говорите на другом языке, вам могут предоставить бесплатную языковую помощь. Посетите наш веб-сайт или позвоните по номеру, указанному на вашей идентификационной карточке участника плана. (Russian)

Si ou pale yon lòt lang ki pa Anglè, wap jwenn sèvis asistans pou lang gratis ki disponib. Vizite sitwèb nou an oswa rele nan nimewo telefòn ki sou kat idantifikasyon manm ou an. (Haitian Creole)

영어가 아닌 언어를 쓰시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 저희 웹사이트를 방문하시거나 귀하의 ID 카드에 기재되어 있는 번호로 전화해 주십시오. (Korean)

Nel caso Lei parlasse una lingua diversa dall'inglese, sono disponibili servizi di assistenza linguistica gratuiti. Visiti il nostro sito web oppure chiami il numero di telefono presente sul Suo tesserino identificativo. (Italian)

אויב איר רעדט א שפראך אויסער ענגליש, זענען שפראך הילף סערוויסעס אוועילעבל. באזוכט אונזער וועבזייטל אדער רופט דעם טעלעפאן נומער אויף אייער מעמבער אידענטיפיקאציע קארטל. (Yiddish)

যদি আপনি ইংরেজী ব্যতীত অন্য কোনো ভাষায় কথা বলেন তাহলে বিনামূল্যের দোভাষীর পরিষেবা উপলব্ধ আছে। আমাদের ওয়েবসাইট দেখুন এবং আপনার সদস্য পরিচয়পত্রে থাকা ফোন নম্বরে ফোন করুন। (Bengali)

Jeżeli nie posługują się Państwo językiem angielskim, dostępne są bezpłatne usługi wsparcia językowego. Proszę odwiedzić naszą witrynę lub zadzwonić pod numer podany na Państwa karcie członkowskiej. (Polish)

إذا كنت تتحدث لغة غير الإنجليزية، فإن خدمات المساعدة اللغوية المجانية متاحة. تفضل بزيارة موقعنا على الويب أو اتصل برقم الهاتف الموضح على بطاقة هوية العضو الخاصة بك. (Arabic)

Si vous parlez une autre langue que l'anglais, des services d'assistance linguistique gratuits vous sont proposés. Visitez notre site Internet ou appelez le numéro figurant sur votre carte d'identification de membre. (French)

اگر آپ انگریزی کے علاوہ دوسری زبان بولتے ہیں تو، زبان سے متعلق مدد کی مفت خدمات دستیاب ہیں۔ ہماری ویب سائٹ ملاحظہ کریں یا اپنے ممبر کے شناختی کارڈ پر درج فون نمبر پر کال کریں۔ (Urdu)

Kung hindi Ingles ang wikang inyong sinasalita, may maaari kayong kuning mga libreng serbisyo ng tulong sa wika. Bisitahin ang aming website o tawagan ang numero ng telepono na nasa inyong identification card bilang miyembro. (Tagalog)

Εάν ομιλείτε άλλη γλώσσα εκτός της Αγγλικής, υπάρχουν δωρεάν υπηρεσίες στη γλώσσα σας. Επισκεφθείτε την ιστοσελίδα μας ή καλέστε τον αριθμό τηλεφώνου που αναγράφεται στην κάρτα ταυτότητας μέλους που έχετε. (Greek)

Nëse nuk flisni gjuhën angleze, shërbime ndihmëse gjuhësore pa pagesë janë në dispozicionin tuaj. Vizitoni faqen tonë në internet ose merrni në telefon numrin e telefonit në kartën tuaj identifikuese të anëtarit. (Albanian)