

# 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 \_\_\_\_\_ Date \_\_\_\_\_ Dispensed as Written \_\_\_\_\_ Date \_\_\_\_\_

**Delivery Information**

Ship to:  Patient  Prescriber/Clinic  
 Pick up at an Albertsons Companies Pharmacy  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Date Medication Needed: \_\_\_\_\_

It's as simple as **caring.**

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

E-Scribe Information:  
 Albertsons/Safeway Pharmacy • 12874 E. Florence Ave.  
 Santa Fe Springs, CA 90670 • NCPDP 5617418 • NPI 1164451100