Pokonza® (potassium Chloride for oral solution) Referral Form

carwin cares | Zeal Specialty Pharmacy

PHONE: 888-412-9325 FAX: 877-329-9325 eRx NPI: 1093424905 www.zealsp.com

Remove above portion before faxing. Please complete the form in its entirety and fax with requested clinicals to the number above.

Pok26-01

PATIENT INFORMATION

First Name	Last Name	Date of Birth ____ /____ / ____	Gender ☐ Male ☐ Female
Address	City	State	Zip
email	Home Phone	Cell Phone	

PRESCRIBER INFORMATION

Prescriber Full Name	Prescriber Credential		
Practice Address	City	State	Zip
Office email	Office Phone	Office Fax	Cell Phone
Practice Contact Person	Prescriber NPI	Preferred Contact Method ☐ Email ☐ Phone ☐ Fax	

CLINICAL INFORMATION – *please include any relevant office visit/lab notes to support this prescription*

Patient is ☐ Naïve / New Start ☐ Therapy Restart ☐ Existing Treatment | Patient Weight _____kg

Allergies ☐ NKDA ☐ Drug Allergies (please list)

Previously Tried (please check name and include dates)

- ☐ Potassium Chloride (KCl) tablets/capsules Date ____ /____ / ____
- ☐ Potassium Chloride Oral Solution Date ____ /____ / ____
- ☐ Potassium-Rich Diet Date ____ /____ / ____
- ☐ Other Date ____ /____ / ____

Current Medications (please list name and dose):

Reason(s) for Therapeutic Failure/Therapy Not Tried:
- ☐ Previous adverse reaction(s)
- ☐ History of pill dysphagia
- ☐ Other (please list)

ICD-10 Code
- ☐ E87.6 Hypokalemia
- ☐ Other: ________________________

PRESCRIPTION – *please check all boxes across row*

Medication	Dose/Strength	Directions	Quantity	Refills
☐ Pokonza® (potassium chloride for oral solution)	☐ 10 mEq ☐ 15 mEq	*Adults: Treatment of Hypokalemia* ☐ Take 40 mEq to 100 mEq by mouth in 2 to 5 divided doses. Total daily dose should not exceed 200 mEq in a 24-hour period *Adults: Maintenance or Prophylaxis of Hypokalemia* ☐ Take 20 mEq by mouth daily *Pediatric (0-16 years) Treatment of Hypokalemia* ☐ Take an initial dose of 2 - 4 mEq/kg/day by mouth in divided doses. Do not exceed as a single dose 1 mEq/kg or 40 mEq, whichever is lower. Total daily dose should not exceed 100 mEq. *Pediatric (0-16 years) Maintenance or Prophylaxis of Hypokalemia* ☐ Take 1 mEq/kg/day by mouth. Do not exceed 3 mEq/kg/day	☐ 30 pouches ☐ 60 pouches ☐ ___________	☐ 11 ☐ _____

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's signature: _________________________________ ☐ MD ☐ DO ☐ PA ☐ CRNP **Date:** ____ /____ / ____

NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

Note: *The information contained in this document will become a legal prescription. Prescriber is to comply with all state-specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state-specific requirements could result in outreach to the prescriber.*

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