



DEPARTMENT OF WORKFORCE EDUCATION  
 ARKANSAS REHABILITATION SERVICES  
 ARKANSAS KIDNEY DISEASE COMMISSION  
 26 CORPORATE HILL DRIVE  
 LITTLE ROCK, ARKANSAS 72205  
 PHONE (501) 686-2807 ♦ FAX (501) 686-2831



REQUEST FOR: FOSRENOL  RENVELA  DATE: \_\_\_\_\_

- |   |
|---|
| <ol style="list-style-type: none"> <li>1. Patient's calcium phosphorus product must be <u>72</u> or greater, (AND/OR)</li> <li>2. Calcium level must be <u>10.0</u> or greater while off vitamin D analog;</li> <li>3. A copy of the patient's lab report must be returned with this form.</li> </ol> |
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(NOTE: ALL INFORMATION MUST BE COMPLETED AND LEGIBLE)

Patient's Name: \_\_\_\_\_ SSN: \_\_\_\_\_  
 Contact Information: \_\_\_\_\_ Tel: ( ) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Patient has: Medicare  Medicaid  Private Insurance with Rx Coverage  None

Is this patient compliant in taking his/her medication? Yes  No

What other avenues (if any) of therapy have been exhausted and are in ineffective?  
 \_\_\_\_\_  
 \_\_\_\_\_

Nephrologists Name: \_\_\_\_\_ Tel: ( ) \_\_\_\_\_  
 Contact Information: \_\_\_\_\_ Fax: ( ) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Social Worker: \_\_\_\_\_ Tel: ( ) \_\_\_\_\_  
 Contact Information: \_\_\_\_\_ Fax: ( ) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Nephrologist's Signature: \_\_\_\_\_

AKDC USE ONLY	
Approved <input type="checkbox"/>	Denied <input type="checkbox"/>
_____ <i>Signature</i>	_____ <i>Date</i>

Revised 10/01/08