Injectafer

Provider Order Form

PATIENT INFORMATION

Patient Name: DOB:

Patient Home Phone: Patient Cell Phone: Patient Email:

Address: City: State: Zip Code:

Emergency/Alternate Contact Name: Emergency/Alternate Contact Phone:

☐ NKDA ☐ Allergies: Weight lbs/kg: Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy ☐ Therapy Change Last infusion date (if applicable):

REQUIRED DOCUMENTATION

☐ Labs ☐ Insurance Card (front and back) ☐ Current Medications ☐ History/Progress Notes

☐ Does the patient have an intolerance, contraindication, or documented tried and failed use of oral iron? ☐ Yes ☐ No

☐ Does the patient have an intolerance or documented tried and failed use of an IV iron product? ☐ Yes ☐ No If yes, which drug(s)? _____

ICD-10 CODE

Primary ICD-10:

☐ Iron Deficiency Anemia

☐ Iron Deficiency Unspecified

☐ Iron Deficiency Anemia secondary to Inadequate Dietary Iron Intake

Other : _____

Secondary ICD-10:

☐ Adverse effect of other drug (oral iron intolerance or not adequate)

☐ End-stage Renal Disease

Intestinal Malabsorption

Chronic Kidney Disease

Other: _____

PRE-MEDICATION ORDER

Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mg PO

Cetirizine (Zyrtec) ☐ 10mg PO

Loratadine (Claritin) ☐ 10mg PO

Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV

Methylprednisolone (Solu-Medrol) ☐ 40mg IV ☐ 125mg IV

Hydrocortisone (Solu-Cortef) ☐ 100mg IV

Other: _____ Dose:_____ Route:_____ Frequency: _____

MEDICATION ORDER

Injectafer **If the patient has Aetna, Cigna, Humana, or UHC, the patient must try and fail Venofer first**

☐ **Patient weighing less than 50kg (110 lbs.)** ☐ **Dose:** Injectafer 15mg/kg IV ☐ **Frequency:** Give 2 doses at least 7 days apart not to exceed 1500mg

☐ **Patient weighing 50kg (110 lbs.) or greater** ☐ **Dose:** Injectafer 750mg IV ☐ **Frequency:** Give 2 doses at least 7 days apart not to exceed 1500mg

PROVIDER INFORMATION

Provider Name: Provider Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

SPECIAL INSTRUCTIONS

Provider Name **Provider Signature** **Date** ☐ Check here if this is a stat order

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.