Infusion for Health
77 Rolling Oaks Drive, Suite 201
Thousand Oaks, CA 91361
Phone: 805-719-3700 Fax: 805-852-2636

INJECTAFER ORDER (IV Iron)

(ferric carboxymaltose injection)

Please fax a copy of patient's demographics, insurance information, current lab results, H&P relevant to the diagnosis & Rx, and current medications.

Date: ____/____/____

Patient Name: ____ DOB: ____/____/____

Allergies: ____ Wt: ______ lbs / kg Ht:__________

**** 2 diagnoses needed for insurance approval and coverage.**
(1° dx has to be iron deficiency anemia, 2° dx the cause of anemia)

ICD-10: 1- _______________________________________ 2- ____

Patient MUST have tried and failed oral iron. Has the patient tried oral iron? ☐ Yes ☐ No

HEMOGLOBIN Result : _________________________ Date: ___________________________________

PRE-MEDICATIONS: (Usually not indicated)

Benadryl	☐ **PO**	☐ **IV**	☐ **25mg**	☐ **50mg**	☐ **Pre med**	☐ **PRN**
Acetaminophen	☐ **PO**		☐ **650mg**		☐ **Pre med**	☐ **PRN**

Injectafer (ferric carboxymaltose) IV Dosing

Dose: ☐ 750 mg (>50 kg) Or _________ 15 mg/kg (<50 kg)

Frequency: once weekly X 2 weeks
Total cumulative dose up to 1500 mg per course.

Printed Provider's Name: ____ NPI: ____________________

Provider's Signature: ____ Date:_____/_____/_____

Office phone number: _______________________________ Office Fax:______________________________

Office address: ____Contact person: __________________

Revised 9/26/17