Injectafer Order (IV Iron)

(ferric carboxymaltose injection)

INFUSION FOR HEALTH

Ph: 805-719-3700 | Fax: 805-852-2636

Date: ___/___/___ Treatment Location: _____

***Please fax a copy of the following patient information:** ☐ Demographics ☐ Insurance Information ☐ Current Lab Results ☐ H & P Relevant to the Diagnosis and Rx ☐ Current Medications

PATIENT INFORMATION

Patient Name: _____

DOB: ___/___/___

Allergies: _____

Weight: _____ lbs / kg Height: _____

Diagnosis: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: ___/___/___

Phone: (___) ___-____ Fax: (___) ___-____

Office Address: _____

Contact Person: _____

QUALIFIERS

****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 (<50kg)

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

Revised 12/01/20