# Injectafer Order (IV Iron)

## (ferric carboxymaltose injection)

InfusionForHealth.com
Ph: 888-777-1945 | Fax: 805-852-2636

Date: _____ Treatment Location: _____

***Please fax a copy of the following patient information:** ☐ Demographics ☐ Insurance Information ☐ Current Medications ☐ H & P Relevant to the Diagnosis and Rx ☐ Current CBC, Iron, Ferritin Labs

### 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: _____

Contact Email: _____

### 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 -** _____ D50.9 **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

Date of Last Treatment, If Continuation:

**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