P: 832-813-8932

F: 888-883-9901

INJECTAFER ORDER FORM

PATIENT INFORMATION

PATIENT NAME: _____ **DOB** _____/_____/_____ **PHONE:** (_____) - _____ - _____

PLEASE ATTACH A COPY OF THE PATIENT'S INSURANCE INFORMATION AND DEMOGRAPHICS

INJECTAFER ORDERS

MEDICATION: INJECTAFER 1500MG

☐ **PATIENT WEIGHT (>110 LBS): 1500 MG IV GIVEN OVER 2 DOSES, AT LEAST 7 DAYS APART**

☐ **PATIENT WEIGHT (<110LBS): 15MG/KG IV GIVEN OVER 2 DOSES, AT LEAST 7 DAYS APART**

***LAST INFUSED ON:** _____

MEDICAL INFORMATION

DIAGNOSIS: IRON DEFICIENCY ANEMIA

☐ **D50.0 - IRON DEFICIENCY SECONDARY TO BLOOD LOSS (CHR)**

☐ **D50.1 - SIDEROPENIC DYSPHAGIA**

☐ **D50.8 - OTHER IRON DEFICIENCY ANEMIAS**

☐ **D50.9 - IRON DEFICIENCY ANEMIA, UNSP**

☐ **D63.0 - ANEMIA IN NEOPLASTIC DISEASE**

☐ **D63.1 - ANEMIA IN CHRONIC KIDNEY DISEASE**

☐ **D63.8 - ANEMIA IN OTHER CHRONIC KIDNEY DISEASE**

PATIENT'S MOST RECENT WEIGHT: _____**LBS** **HEIGHT:** _____ **INCHES**

ALLERGIES: _____ ☐ **K.D.A**

DATE OF LAST IRON PANEL: _____ **DATE OF LAST CBC:** _____

HB RESULT: _____ **G/DL** **TSAT RESULT:** _____ **%** **FERRITIN LEVEL:** _____**MCG/DL**

PLEASE ATTACH ALL MEDICAL RECORDS, INCLUDING LAB WORK, CLINICAL NOTES, HOSPITALIZATION RECORDS, OR SURGICAL PROCEDURES

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing our company (based on preferred location) and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

PHYSICIAN NAME (PRINTED): _____ **NPI:** _____

PHONE: _____ **FAX:** _____ **CONTACT PERSON:** _____

PHYSICIAN NAME (SIGNED): _____ **DATE:** _____