



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: _____ N.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: _____

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