P: 832-813-8932

F: 888-883-9901

IRON RX FORM

PATIENT INFORMATION

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

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

MEDICATION

REFILLS
☐ **1 YEAR**
☐ _____

INJECTAFER (PLEASE SELECT)
☐ 1500 MG IV GIVEN OVER 2 DOSES, AT LEAST 7 DAYS APART (>110LBS)
☐ 15MG/KG IV GIVEN OVER 2 DOSES, AT LEAST 7 DAYS APART (<110LBS)

☐ VENOFER _____MG IV FOR _____WEEKS, TOTAL OF _____ DOSES

☐ FERRLECIT 125 MG IV ONCE A WEEK, FOR A TOTAL OF 8 DOSES
*PRE-MED: 40MG SOLUMEDROL IV, 25MG BENADRYL PO

☐ FERAHEME 510 MG IV GIVEN OVER 2 DOSES, 3-8 DAYS APARTS

☐ MONOFERRIC 1000 MG IV FOR A TOTAL OF ONE DOSE (>110LBS)
☐ MONOFERRIC 20MG/KG IV FOR A TOTAL OF ONE DOSE (<110LBS)

PRE-MEDICATIONS

BENADRYL IV _____ MG
REGLAN IV _____ MG
SOLUMEDROL IV _____ MG
ZOFRAN IV _____ MG
OTHER IV_____ MG

BENADRYL PO _____ MG
TYLENOL PO _____ MG
ZYRTEC PO _____ MG
ZOFRAN PO _____ MG
ZANTAC PO _____ MG
OTHER PO_____ MG

IF APPLICABLE, DATE OF LAST INFUSION: _____

MEDICAL INFORMATION

ALLERGIES: _____ ☐ **N.K.D.A**

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

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

PREVIOUSLY FAILED MEDICATIONS/DOSE:

#1_____ **DATE RANGE:** _____
#2_____ **DATE RANGE:** _____
#3_____ **DATE RANGE:** _____

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

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

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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