P: 832-813-8932

F: 888-883-9901

# OB/GYN 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)

☐ RECLAST 5MG/100ML IV FOR ONE DOSE YEARLY

☐ PROLIA 60MG SQ EVERY 6 MONTHS

☐ VENOFER _______MG IV FOR ______WEEKS, TOTAL OF _______ DOSES

☐ ROCEPHIN _______ GM IV DAILY FOR _______ DAYS

☐ ZITHROMAX 500MG IV DAILY ______ DAYS

☐ SOLUMEDROL 1GM IV DAILY FOR _______ DAYS

☐ HYDRATION (PLEASE SELECT):
- ☐ 0.9% NORMAL SALINE IV
- ☐ D5 0.45% NS IV
- ☐ OTHER: ________________________

DOSAGE (PLEASE SELECT): ☐ 500ML ☐ 1L ☐ 2L

FREQUENCY: EVERY ________________________________________

## PRE-MEDICATIONS

BENADRYL IV __________ MG
REGLAN IV __________ MG
SOLUMEDROL IV __________ MG
ZOFRAN IV __________ MG
OTHER IV______________________________ MG
VITAMINS IV (SPECIFY DOSE): ___________________________________

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

T-SCORE (<.2.5, OTHERWISE DOCUMENTED FRACTURES): ____________________
eGFR: ________________________

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

### OTHER NON-RELATED IDA DIAGNOSIS

ICD-10: ____________________
DIAGNOSIS: ____________________________________________

## 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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