Local Infusion

MYLOCALINFUSION.COM

INJECTAFER (FERRIC CARBOXMALTOSE) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____

Allergies: _____

PRIMARY DIAGNOSIS (Provider must specify)

❑ Iron Deficiency Anemia, ICD 10: D50._____

❑ Iron Deficiency, ICD 10: E61.1

❑ NDD-CKD: Stage _____, ICD 10: N18._____

❑ Other underlying disease: _____

SECONDARY DIAGNOSIS (Provider must specify)

❑ Anemia in CKD, ICD 10: D63.1

❑ Anemia in Chronic Disease, ICD 10: D63.8

❑ Heart Failure ICD, 10: I50._____

❑ Other:_____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI:_____

Signature: _____ Date: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

PRE-MEDICATION (Not typically indicated)

❑ Acetaminophen (Tylenol) 500 mg PO

❑ Famotidine 20 mg IV

❑ Methylprednisolone (Solu-Medrol) 125 mg IVP

❑ Benadryl 25mg PO

❑ Cetirizine (Zyrtec) 10 mg PO

❑ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Injectafer	❑ 750 mg ❑ 15 mg/kg (Max of 1,000 mg) x 1 dose	❑ IV	❑ x1 dose ❑ x2 doses at least 7 days apart

❑ New Start Therapy ❑ Continuation of Therapy Date of last dose (if applicable): _____

LABS / SPECIAL INSTRUCTIONS

FAX NUMBERS: ❒ CT: 203.433.0621 ❒ MD: 240.224.8607 ❒ ME: 207.407.7272 ❒ NH: 603.217.5371
❒ NJ: 201.581.4521 ❒ VA: 703.202.0499

Order valid for 1 year from date of signature unless otherwise specified here: _____