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 PH: 602-346-0204 FAX: 877-637-6691

New Referral Restart Medication/ Order Change
 (New Order Required) Benefits Verification
 Only D/C Infusions
 *indicate name of drug(s)

PATIENT INFORMATION

PHYSICIAN INFORMATION

Name: _____ Date: _____
 DOB: _____ SS# _____
 Phone # _____
 Email: _____

Referring Physician: _____
 Practice Address: _____
 Office Contact: _____
 Contact Phone # _____ Contact Fax # _____
 NPI / TIN _____

INJECTAFER MEDICATION ORDERS

Patient Weight: kg Oral Iron _____ Date: _____ Intolerance

DOSING:
 Injectafer 15mg/kg IV - Give 2 doses at least 7 days apart not to exceed 1500mg - if patient weighing less than 50kg (110lbs)
 Injectafer 750mg IV - Give 2 doses at least 7 days apart not to exceed 1500mg - if patient weighing 50kg (110lbs) or greater

INDICATION/DIAGNOSIS

NOTES (ADDITIONAL INFO)

Primary Diagnosis
 D50.9 Iron Deficiency Anemia, unspecified
 D50.8 Other iron deficiency anemias
 Other Medical Necessity _____

*ICD-10 _____ required

 Referring Physician's Signature Date

REQUIRED DOCUMENTATION

Recent Office notes (along with any therapies tried and outcomes) Current Medication List History and Physical Report
 Lab Results Insurance Cards (front and back) Demographic Sheet

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

CBC
 HCT

APPOINTMENT DATE & TIME: _____

FOR OFFICE USE ONLY