INJECTAFER (ferric carboxymaltose) Referral Order Form

FAX (877) 637-6691

WWW.VASCOINFUSION.COM
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

Name: ______________________________

DOB: ______________ SS# ______________

Phone # ______________

Email: ______________________________

PHYSICIAN INFORMATION

Referring Physician: ______________________________

Practice Address: ______________________________

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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

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

NOTES (ADDITIONAL INFO)

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