INJECTAFER (Ferric Carboxymaltose) Referral Order Form

WWW.PACEINFUSION.COM
PH:330-625-4900
F: 330-685-9355

☐ 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: _____

_____

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 750mg each - if patient weighing less than 50kg (110lbs)
☐ Injectafer 750mg IV - Give 2 - 750mg doses at least 7 days apart - 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**

NOTES (ADDITIONAL INFO)

_____ _____
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