medix infusion

Injectafer Order Form
(ferric carboxymaltose)

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: _____

DOB: _____ Phone: _____ Sex: ☐ M ☐ F

DIAGNOSIS & CLINICAL INFORMATION

Primary ICD 10 Code (Required)

- ☐ D50.9 Iron Deficiency Anemia, Unspecified
- ☐ D50.0 Iron Deficiency Anemia Secondary to Blood Loss (chronic)
- ☐ Other: _____

Secondary ICD 10 Code (Medicare Required)

Code: _____ Description: _____

Weight: _____ ☐ lb ☐ kg Height: _____

Patient Status:

- ☐ New to therapy
- ☐ Continuing therapy (date of last dose _____)

Allergies: _____

PRESCRIPTION

INJECTAFER (ferric carboxymaltose)

Wt < 50 kg: 15 mg/kg IV; give two doses, separated by at least 7 days
Wt > 50 kg: 750 mg IV; give two doses, separated by at least 7 days, not to exceed 1000 mg per administration

Is the patient on any other disease modifying therapy? ☐ **Yes** ☐ **No**

Is yes, please note therapy and last dose: _____

Adverse Events: In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reactions protocol

Other Orders: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING AND INSURANCE APPROVAL

- Signed and completed order
- Patient's demographic and insurance information
- Patient's medication list
- Supporting clinical notes that include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

Lab Results: Hemoglobin and Hematocrit levels within last 30 days
Other iron studies as available: Serum iron, total iron binding capacity (TIBC), serum ferritin, and transferring saturation within the last 30 days

Medix Infusion will collect all necessary labs if not included in referral documents

PRESCRIBER INFORMATION

Prescriber Name: _____

Signature: _____

NPI #: _____ Date: _____

Supervising Physician (if applicable): _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____