

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: M F Ht: _____ Wt: _____ lbs kg
 Primary Language: _____ Allergies: _____
 Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

<ICD 10 CODE REQUIRED>

PRIMARY & SECONDARY ICD 10 CODES REQUIRED

Primary ICD 10 Code

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

Secondary ICD 10 Code (Underlying Condition - Required)

Other: _____

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.
LAB RESULTS: Hemoglobin & Hematocrit levels within last 30 days. Other iron studies as available: Serum iron, total iron binding capacity (TIBC), serum ferritin, and transferrin saturation within last 30 days.

PRESCRIPTION*

Pre-Medications

Acetaminophen: 650 mg PO
 Diphenhydramine: 25 mg PO
 Diphenhydramine: 25 mg IVP
 Famotidine: 20 mg PO
 Methylprednisolone: 125 mg SIVP
 Other: _____

INJECTAFER (ferric carboxymaltose)

Diluted in 250 mL** of 0.9% Sodium Chloride as directed over at least 30 minutes via pump

Loading Dose

IV: (wt < 50 kg): Infuse 15 mg/kg dose twice, separated by at least 7 days
 ** Doses less than 500 mg require dilution in 100 mL of 0.9% Sodium Chloride

Patient Weight: _____ lbs. or _____ kg

IV: (wt > 50 kg): Infuse 750 mg dose twice, separated by at least 7 days

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

If yes, please note therapy and last dose: _____

Post Treatment Observations: The patient is observed for 30 minutes following the first administration.

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

Comments:

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____
 Date: _____ NPI #: _____ Specialty: _____
 Supervising Physician: _____ (If Applicable)
 Address: _____ City: _____ State: _____ Zip: _____
 Contact Name: _____ Phone: _____ Fax: _____ Email: _____