○ **New Prescription/Referral**
○ **Prescription Refill**

VENOFER

Rx:

Patient Name: Patient Weight: kg

DOB:

MEDICATION/Strength: **VENOFER**

☐ 200mg in 100ml NaCl over 15 mins x 5 doses via IV infusion over a 14-day period. Total = 1000mg.
☐ 200mg IV push over 2 to 5 mins x 5 doses over a 14-day period. Total = 1000mg.
☐ **OTHERS:**

Dx: ☐ Iron Deficiency Anemia (D50.9) ☐ **OTHERS** (**Dx + ICD Code 10**):

Pre-Medication:

☐ Solumedrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Tylenol _____mg PO ☐ 650mg ☐ 975mg
☐ Benadryl _____mg ☐ 25mg ☐ 50mg ☐ IV ☐ PO
☐ Others:

ANA Kit Protocol:
☐ OK to use

NPI#:

DEA#:

Physician Signature

Date: (Valid for 1 year)

By affixing my signature, I confirm the medical necessity of the aforementioned therapy, products, and services, as well as my responsibility for the patient's care. I have obtained consent to disclose the mentioned details and any relevant medical or patient information concerning this treatment. I grant the pharmacy permission to contact the insurance company on my behalf to secure authorization for the patient.

PHYSICIAN INFORMATION

Physician Name:

CLINIC:

Contact Information:

Phone: **Fax:** **Email:**
Other:

Office Mailing Address:

Check that the following are included:

☐ **Patient demographics & Insurance attached**
☐ **Clinical progress notes**
☐ **History and Physical**
☐ **Lab Results**
☐ **Other Test Results**
☐ **Diagnosis (supporting)**
☐ **Medication List**