INJECTAFER

FAX: 725.228.5220

eMediate INFUSION

☐ New Prescription/Referral
☐ Prescription Refill

 # Of Refills:

PATIENT INFORMATION

*Please attach the copy of patient insurance & ID (front and back)

Name:	DOB:	Weight: kg

PHYSICIAN INFORMATION

Prescriber Name:	Phone:	Fax:
Office Contact:	*Email (for the referral update):	
Clinic:	Address:	
NPI:		
Patient's PCP Name:	Phone:	Fax:
Clinic:	Address:	
NPI:		

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

INJECTAFER
OR
FERRIC CARBOXYMALTOSE

☐ 1st Dose: 750mg IV infusion in no more than 250ml of 0.9% NaCl over at least 15 mins
☐ 2nd Dose: 7 days after the 1st dose, 750mg IV infusion in no more than 250ml of 0.9% NaCl over at least 15 mins or slow IV push over 7.5 mins

Heart failure Injectafer IV dosing (standard)
please indicate initial dose and maintenance dose (if applicable)

☐ Day 1 dose: ☐ 500mg ☐ 1000mg
☐ Week 6 dose: ☐ 500mg ☐ 1000mg

☐ Administer a maintenance dose of 500mg at week 12, 24 and 36 if ferritin <100 ng/mL or ferritin 100-300 ng/mL with transferrin sat <20%

*Serum ferritin and transferrin required prior to each maintenance dose

Other dosing:_____

_____

☐ **Preferred Brand:** _____

As required by the state, to ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, EIC is authorized to administer a generic or biosimilar.

☐ **Tried and failed oral iron medication** *(Please add to doctors clinical notes)*

Pre-Medication:

☐ Solumedrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Others: _____

☐ Tylenol _____ mg PO
☐ 650 mg ☐ 975 mg

☐ Benadryl _____ mg PO
☐ 25 mg ☐ IV
☐ 50 mg ☐ PO

ANA Kit Protocol:

☐ OK to use

Dx:

Please note: Injectafer prescriptions require a primary ICD-10 code for ID and IDA as well as a secondary code for the underlying condition causing ID or IDA.

Primary ICD-10:_____

☐ Iron Deficiency Anemia
☐ Iron Deficiency Anemia s/t inadequate Dietary Iron Intake
☐ Others:_____

Secondary ICD-10:_____

☐ End-stage Renal Disease
☐ Chronic Kidney Disease
☐ Iron Deficiency in heart failure
☐ Intestinal Malabsorption
☐ Others:_____

PRESCRIBER SIGNATURE: x

Date (Valid for 1 year):

I authorize eMediate Infusion Center, PLLC , Assist Point Clinical or its authorized representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to eMediate Infusion Center.

REQUIRED INFORMATION

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

We can do patient teaching for IV/IM/SQ injections if needed. One time or multiple visits. If insurance allows we can also administer SQ/IM shot.