***Patient Insurance & ID (front and back) are needed**

- New Prescription/Referral
- Prescription Refill

INJECTAFER

Rx:

Patient Name:

Patient Weight: kg

DOB:

MEDICATION/Strength: **INJECTAFER**

- ☐ **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
- ☐ **OTHERS:**

Dx:

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

Pre-Medication:

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

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**