IV Iron Medication Rx Form

Please sign (do not stamp) and note any changes on Rx and fax to the SMA Treatment Center and Southwest Medical Pharmacy (SMRx).

To: _____ Fax To: Treatment Center (702) 579-1027 & SMRx (702) 838-1475

Patient Name: _____ Date of Request: _____

DOB: _____ Ht:_____ Wt: _____ Allergies: _____

Patient's address: _____ Pt. Telephone #: _____

Insurance to be billed: _____ Diagnosis Code: _____

Select Medication and Dose (Check or specify other)

☐ **Venofer: 200 mg IV in 100 mL NS over 15 minutes x 5 doses within 14 days.**
Recommended for pregnant patients, patients with multiple drug allergies or CKD.

☐ Other IV Iron medication order: _____

Patient must meet UHC policy in order to receive other IV Iron medications. Current UHC policy states that patient must have treatment failure with TWO of Infed, Venofer, or Ferrlecit prior to trying Feraheme, Injectafer, or Monoferric.

Prescriber Name (print): _____

Prescriber Signature (No stamp): _____**Date**: _____

Prescriber Call Back Number: _____