eMediateINFUSION center

- ○ New Prescription/Referral
- ○ Prescription Refill

INJECTAFER

Rx:

Patient Name:

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
- ☐ 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)

PHYSICIAN INFORMATION

Physician Name:

CLINIC:

Contact Information:

Phone:

Fax:

Other:

Email:

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

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