CARDIOLOGY

FAX: 725.228.5220

☐ New Prescription/Referral
☐ Prescription Refill

eMediate INFUSION

 # 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)

Diagnosis:

ICD-10 Code:

LEQVIO (inclisiran)

☐ 284mg SubQ at Day 0, Months 3, and every 6 months (initial start) x 1 year
☐ 284mg subcutaneously every 6 months x 1 year
☐ Others: _____

Diagnosis:

Iron Deficiency in heart failure

ICD-10 Code:

☐ **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
☐ Others: _____

☐ **VENOFER OR**
IRON SUCROSE

☐ 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: _____

☐ **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)*

☐ May substitute with any formulary-approved intravenous iron preparation per insurance coverage

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

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.

Please attach the following

☐ Patient demographics ☐ Insurance attached ☐ Diagnosis(supporting) ☐ History & Physical
☐ Lab Results ☐ Clinical progress notes ☐ Medication list ☐ Other Test Results
☐ Cholesterol with LDL-C (Leqvio)

***If TB or Hep B results are positive - please provide documentation of treatment or medical clearance & a negative CXR (TB+)**