O New Prescription/Referral
O 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 ☐ 50mg ☐ IV ☐ 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**