

PATIENT INFORMATION:

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: New to Therapy Continuing Therapy **Next Treatment Date:** _____

DIAGNOSIS AND ICD-10 CODE:

Patient Weight: _____ lbs. (required) Allergies: _____

Primary ICD-10: _____

- Iron Deficiency Anemia
- Iron Deficiency Unspecified
- Iron Deficiency Anemia secondary to Inadequate Dietary Iron Intake
- Other medical necessity: _____

Secondary ICD-10: _____

- Adverse effect of other drug (oral iron intolerance or not adequate)
- End-stage Renal Disease
- Intestinal Malabsorption
- Chronic Kidney Disease
- Other medical necessity: _____

VENOFER ORDER

- Venofer 200mg IV - Administer 5 doses over a 14 day period
- Venofer 200mg IV weekly x 5 weeks
- Other: _____

INJECTAFER ORDER**

- | | |
|---|--|
| <input type="checkbox"/> Patient weighing less than 50kg (110 lbs.)
Dose: Injectafer 15mg/kg IV
Frequency: Give 2 doses at least 7 days apart not to exceed 1500mg | <input type="checkbox"/> Patient weighing 50kg (110 lbs.) or greater
Dose: Injectafer 750mg IV
Frequency: Give 2 doses at least 7 days apart not to exceed 1500mg |
|---|--|

MONOFERRIC ORDER**

- | | |
|---|---|
| <input type="checkbox"/> Patient weighing less than 50kg (110 lbs.)
Dose: Monoferric 20mg/kg IV x 1 dose | <input type="checkbox"/> Patient weighing 50kg (110 lbs.) or greater
Dose: Monoferric 1000mg IV x 1 dose |
|---|---|

If the patient has Aetna, Cigna, Humana, or UHC, the patient must try and fail Venofer first

Lab Orders: _____ **Lab Frequency:** _____

Other orders: _____

PROVIDER INFORMATION:

By signing this form, you authorize US Infusions and its staff to handle prior authorizations, coordinate with insurance providers, and determine the patient's preferred site of care.

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

****PLEASE COMPLETE BOTH SIDES OF THIS FORM****

PATIENT INFORMATION:

Patient Name: _____ DOB: _____ Phone: _____

REQUIRED ASSOCIATED DOCUMENTATION:

- Signed and completed order (MD/prescriber to complete page 1)
- Patient demographic information and insurance information
- Include patient's medication list
- Supporting clinical notes (H&P) to support primary diagnosis
 - Does the patient have an intolerance, contraindication, or documented tried and failed use of oral iron?
 Yes No
 - Does the patient have an intolerance or documented tried and failed use of an IV iron product?
 Yes No If yes, which drug(s)? _____
- Labs showing iron deficiency anemia attached
- Other medical necessity: _____

REQUIRED PRE-SCREENING

- Labs indicating iron deficiency - please attach

