



OB/GYN REFERRAL & ORDER SET

P: 331-236-0610 | F: 331-314-8989 Fax this form with insurance cards + clinical notes

REFERRING FOR	☐ IV IRON (iron deficiency anemia)	☐ IV HYDRATION (hyperemesis / dehydration)	☐ BOTH
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PATIENT INFORMATION				
PATIENT NAME		DATE OF BIRTH		PHONE
ADDRESS		CITY / STATE / ZIP		WEIGHT (for iron dosing)
ALLERGIES	PATIENT STATUS	PREGNANT	WEEKS GEST.	IVF / ICSI
	☐ New ☐ Continuing	☐ Y ☐ N		☐ Y ☐ N

REFERRING PRESCRIBER & INSURANCE			
PRESCRIBER NAME	PHONE	FAX	NPI #
PRACTICE / OFFICE CONTACT		EMAIL	NEXT TREATMENT DATE
PRIMARY INSURANCE	POLICY #	GROUP #	
SECONDARY INSURANCE	POLICY #	GROUP #	

DIAGNOSIS ICD-10 required — check all that apply	
IRON DEFICIENCY / ANEMIA	HYPEREMESIS / DEHYDRATION
☐ D50.0 IDA, chronic blood loss ☐ D50.9 IDA, unspecified ☐ D62 Acute blood loss anemia ☐ N92.0 Heavy menses ☐ O99.011 / .012 / .013 Anemia in pregnancy, 1st / 2nd / 3rd trimester ☐ O99.02 Anemia, childbirth ☐ O99.03 Anemia, puerperium	☐ O21.0 Mild hyperemesis (<20 wks) ☐ O21.2 Late vomiting ☐ O21.1 Hyperemesis w/ metabolic disturbance ☐ O21.8 / O21.9 Other / unspecified vomiting of pregnancy ☐ E86.0 Dehydration ☐ E87.1 Hyponatremia ☐ E87.6 Hypokalemia
OTHER ICD-10	DIAGNOSIS DESCRIPTION

SECTION A — IV IRON complete only if referring for iron	
Monofer[®] <i>ferric derisomaltose</i>	☐ Under 50 kg (110 lbs): 20 mg/kg IV × 1 dose ☐ 50 kg or more: 1,000 mg IV × 1 dose
Injectafer[®] <i>ferric carboxymaltose</i>	☐ Under 50 kg: 15 mg/kg IV ☐ 50 kg or more: 750 mg IV — both: 2 doses ≥ 7 days apart, max 1,500 mg
Let us choose <i>or write one in</i>	☐ Dispense whichever IV iron the patient's plan covers — LIVbetter to select (Monofer [®] or Injectafer [®]) ☐ Other iron product: _____ Dose / schedule: _____
Venofer[®] <i>iron sucrose</i>	CASH PAY ONLY · \$250 per dose · not billed to insurance ☐ 200 mg IV × 5 doses over 14 days ☐ 200 mg IV weekly × 5 weeks ☐ Other: _____
Before you send	Aetna, Cigna, Humana and UHC require a documented trial and failure of IV iron sucrose before approving Monofer [®] or Injectafer [®] — or a letter of medical necessity.

SECTION B — IV HYDRATION / HYPEREMESIS complete only if referring for hydration	
IV fluid	☐ 0.9% Normal Saline ☐ Lactated Ringer's Volume: ☐ 500 mL ☐ 1,000 mL ☐ _____ Infuse over: ☐ 1 hr ☐ 2 hr ☐ _____
Thiamine <i>vitamin B1</i>	☐ 100 mg IV ☐ Other: _____ mg IV ☐ Add to first liter ☐ Separate IVPB <i>Give before any dextrose-containing fluid.</i>
Ondansetron <i>Zofran</i>	☐ 4 mg IV ☐ 8 mg IV ☐ Other: _____ mg IV ☐ With each visit ☐ One dose only
Additional <i>optional</i>	☐ Pyridoxine (B6) _____ mg IV ☐ Famotidine 20 mg IV ☐ Diphenhydramine 25 mg IV ☐ Metoclopramide 10 mg IV ☐ Magnesium sulfate _____ g IV ☐ Methylprednisolone _____ mg IV ☐ KCl per labs ☐ Other: _____
Frequency	☐ One visit ☐ Daily × _____ days ☐ _____ visits/week × _____ weeks ☐ PRN, max _____ visits

PREMEDICATIONS, LABS & SIGNATURE		
Premeds	☐ Acetaminophen ☐ 500 ☐ 1,000 mg PO ☐ Diphenhydramine 25 mg ☐ PO ☐ IV ☐ Loratadine 10 mg PO ☐ Cetirizine 10 mg PO ☐ Solu-Medrol _____ mg IVP ☐ Normal Saline 500 mL IV ☐ Other: _____	
Labs	Orders: _____ Frequency: ☐ Each infusion ☐ Other: _____ Drawn by: ☐ LIVbetter ☐ Referring provider	
Attach	☐ Insurance cards ☐ Medication list ☐ Clinical notes ☐ Iron labs (CBC, ferritin, TSAT) ☐ Oral iron failed / not tolerated	
PRESCRIBER SIGNATURE — required	DATE	DISPENSE AS WRITTEN
X		☐ Yes

By signing, the prescriber authorizes LIVbetter Infusions to secure prior authorization and submit claims to the patient's insurance. Where state law requires it, check "Dispense as written" to prevent generic substitution.