Injectafer® (ferric carboxymaltose) Order Form

Please include the following (required):
1. Patient Demographics & Insurance Information
2. Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (ICD-10)

Patient Name ____________________ **DOB** ____________________

Allergies ____________________ **Patient Phone** ____________________

Primary Diagnosis (must include ICD-10 code)
☐ Iron Deficiency Anemia ____________ ☐ Iron Deficiency Unspecified ____________
☐ Anemia, Unspecified ____________ ☐ Other Medical Necessity____________
Secondary Diagnosis
☐ Adverse effect of biologic drug____________☐ Malabsorption____________
☐ Chronic kidney disease____________☐ Other Medical Necessity____________

Prescription Orders: Injectafer® (ferric carboxymaltose) 750mg/15ml single use vial

Sig: Give 750mg/15ml IV over 30 minutes once a week for ______ doses

Premeds: ____

Physician Name **Phone** **Fax**

Physician's signature **Date**

Fax completed form to (214) 887-0436.Contact us directly at: (214) 276-5642.
Or visit us online at www.ntinfusioncenters.com

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