**Richmond**
7110 Forest Ave, Suite 203
Richmond, VA 23226

INFUSION SOLUTIONS

**Prince George**
2025 Waterside Rd, Suite 100B
Prince George, VA 23875

# Physician Order - Injectafer (Ferric Carboxymaltose)

| PATIENT INFORMATION | |
|---|---|
| Name: | DOB: |
| Allergies: | Phone Number: |

| REFERRAL STATUS |
|---|
| ☐ New Referral ☐ Dose/Frequency Change ☐ Order Renewal |

| Location Preference (optional) |
|---|
| ☐ Richmond ☐ Prince George |

** If the patient has a central line - we need official placement report, diagnostic imaging to confirm tip placement and date of last access **

| DIAGNOSIS AND ICD-10 CODE | |
|---|---|
| ☐ Iron Deficiency Anemia | D50.9 |
| ☐ Iron Deficiency Anemia due to blood loss | D50.0 |
| ☐ Other: _____ | ICD10 _____ |

| **REQUIRED** DOCUMENTATION (must include) | |
|---|---|
| ☐ This signed order form by the provider | ☐ Clinical/Progress Notes |
| ☐ Patient Demographics AND Insurance Information | ☐ Labs and Tests Supporting Primary Dx |
| ☐ CBC results, within 14 days | ☐ Ferritin OR Iron Saturation results, within 14 days |

Is your patient unable to tolerate, or had inadequate response to oral iron supplements? ☐ Yes ☐ No

| MEDICATION ORDERS** | |
|---|---|
| 2-Dose Regimen | ☐ Injectafer 750mg **(>50kg)** infuse IV over 15-30 minutes once, followed by a second IV dose over 15-30 minutes 7 days later |
| | ☐ Injectafer 15mg/kg **(≤50kg)** infuse IV over 15-30 minutes once, followed by a second IV dose over 15-30 minutes 7 days later |
| 1-Dose Regimen | ☐ Injectafer 15mg/kg **(≥50kg)** infuse IV over 15-30 minutes once<br>*****MAXIMUM DOSE OF 1000mg for all weight based dosing***** |

Patient Weight: _____ kg or _____ lb Patient Height: _____ in

| **OPTIONAL** PREMEDICATIONS and LAB ORDERS |
|---|
| ☐ Acetaminophen 650mg PO prior to infusion |
| ☐ Diphenhydramine 25mg PO or IV (per patient preference) prior to infusion |
| ☐ Methylprednisolone 40mg slow IVP prior to infusion |
| ☐ Other PreMed and Lab Order with frequency:_____ |

In the event of an infusion reaction or adverse event, our covering physician will be notified and appropriate medical care will be administered.

| **PRESCRIBER INFORMATION** | | |
|---|---|---|
| Prescriber Name: | NPI: | Contact: |
| Phone: | Fax: | Email: |
| Prescriber Signature: | | Date: |

**Contact us with questions at: 804-442-3558 or email referrals@theinfusionsolution.com**
Fax completed form and ALL required documentation to 804-554-5848
All information contained in this form is strictly confidential and will become part of the patient's record.