Infusion ASSOCIATES®

Phone: (833) 394-0600 Fax: (833) 996-4888

Injectafer Infusion

*Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, and Current Medications and **Recent Visit Notes***

Referral status: ☐ NEW referral ☐ Dose or frequency change ☐ Order renewal

Date: _____/_____/_____

Patient Name: _____ **DOB**: _____/_____/_____

Allergies: _____ **Patient Weight:** _____lbs/kg **Height:**_____

ICD-10: _____, _____, _____

Is this referral **URGENT (**to be administered within 5-7 days) rationale:_____

Does patient have chronic kidney disease? ☐ No ☐ Yes, what stage and ICD10 code? _____
Hemoglobin: _____ Date collected: _____
Ferritin: _____ Date collected: _____
Is patient on hemodialysis: ☐ Yes ☐ No
Is patient currently on an erythropoietin product ? ☐ Yes ☐ No
Is patient unable to tolerate, or had inadequate response to oral iron supplements? ☐ Yes ☐ No

Labs:
☐ Pharmacist to order labs per protocol
Labs to be drawn _____weeks after infusion course is complete:
☐ CBC ☐ Iron Studies (Iron, T-sat, Tibc, Ferritin) ☐ Phosphorus ☐ Other: _____

☐ Pharmacist to dose Injectafer

(Monitor serum phosphate levels in pts at risk for hypophosphatemia who require a repeat course of treatment)

Injectafer (ferric carboxymaltose) **IV**

Dose: ☐ 750 mg ☐ 15mg/kg *(for patients weighing less than 50kg)*

Frequency: q 7days *(must be given 7 days apart)*

Number of doses: _____

Printed Provider Name: _____

Provider Signature: _____

Office Phone Number: _____**Office Fax Number:** _____

Contact Name: _____**Contact Phone Number:** _____

New referring providers, how did you hear about us? ☐Web Search ☐Pharma Rep ☐Drug Locator ☐Patient ☐Word of Mouth ☐IA Clinical Liaison ☐IA Website ☐Facebook ☐Instagram ☐TV/streaming ☐ Other: _____