immersiv HEALTH

INJECTAFER® ORDER FORM

FAX TO: 855.694.4656

PATIENT INFORMATION

PATIENT NAME: _____ **PHONE:** _____

DATE OF BIRTH: _____ **SEX:** ☐ M ☐ F **HEIGHT:** _____ **WEIGHT:** _____ ☐ LBS ☐ KG

ALLERGIES: _____ **PREFERRED CLINIC:** _____

REFERRAL STATUS: ☐ NEW REFERRAL ☐ ORDER CHANGE ☐ ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

☐ D50.0 Iron Deficiency Anemia secondary to blood loss

☐ D50.9 Iron Deficiency Anemia

☐ ICD-10 CODE: _____ DESCRIPTION: _____

REQUIRED DOCUMENTATION

☐ Insurance Information ☐ List of Medications ☐ Most recent History & Physical ☐ Tried & Failed Therapies ☐ Other iron studies if available

☐ Recent hemoglobin, hematocrit within 30 days

MEDICATION ORDER

***For patients Weighing Less Than 50 kg**

☐ Injectafer® (ferric carboxymaltose) 2 doses of 15 mg/kg IV in 100 ml-250 ml NS over 30 minutes separated by at least 7 days

***For patients Weighing greater Than 50 kg**

☐ Injectafer (ferric carboxymaltose) 2 doses of 750 mg IV in 250 ml NS over 30 minutes separated by at least 7 days

Patient to be observed for 30 minutes following infusion.
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRESCRIBER INFORMATION

PROVIDER NAME: _____ **NPI #:** _____

EMAIL: _____ **PHONE:** _____ **FAX:** _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: _____ **CONTACT NAME:** _____
(IF APPLICABLE)

SIGNATURE: _____ | _____ **DATE:** _____
(NO STAMPS)

SUBSTITUTION PERMITTED DISPENSE AS WRITTEN