NORTH TEXAS INFUSION CENTERS

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_____ ☐ Other Medical Necessity_____
Secondary Diagnosis
☐ Adverse effect of biologic drug_____ ☐ Malabsorption_____
☐ Chronic kidney disease _____ ☐ Other Medical Necessity_____
☐ Adverse effects of iron and its compounds initial encounter T45.4X5A

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

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

Premeds: _____

_____
Provider Name **Phone** **Fax**

_____
Provider's signature **Date**

Fax completed form to (214) 887-0436. For insurance questions call (214) 276-5642.
For any other questions please call (469) 480-9649.
Or visit us online at www.ntinfusioncenters.com