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, 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

Updated 06/23/2010