



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: _____

Physician Name

Phone

Fax

Physician'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**