Richmond
7110 Forest Ave, Suite 203
Richmond, VA 23226

INFUSION SOLUTIONS

Prince George
2025 Waterside Rd, Suite 100B
Prince George, VA 23875

Physician Order - Injectafer (Ferric Carboxymaltose)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Phone Number:

REFERRAL STATUS
☐ New Referral ☐ Dose/Frequency Change ☐ Order Renewal

Location Preference (optional)
☐ Richmond ☐ Prince George

** If the patient has a central line - we need official placement report, diagnostic imaging to confirm tip placement and date of last access **

DIAGNOSIS AND ICD-10 CODE	
☐ Iron Deficiency Anemia	D50.9
☐ Iron Deficiency Anemia due to blood loss	D50.0
☐ Other: _____	ICD10 _____

REQUIRED DOCUMENTATION (must include)	
☐ This signed order form by the provider	☐ Clinical/Progress Notes
☐ Patient Demographics AND Insurance Information	☐ Labs and Tests Supporting Primary Dx
☐ CBC results, within 14 days	☐ Ferritin OR Iron Saturation results, within 14 days

Is your patient unable to tolerate, or had inadequate response to oral iron supplements? ☐ Yes ☐ No

MEDICATION ORDERS**	
2-Dose Regimen	☐ Injectafer 750mg **(>50kg)** infuse IV over 15-30 minutes once, followed by a second IV dose over 15-30 minutes 7 days later
	☐ Injectafer 15mg/kg **(≤50kg)** infuse IV over 15-30 minutes once, followed by a second IV dose over 15-30 minutes 7 days later
1-Dose Regimen	☐ Injectafer 15mg/kg **(≥50kg)** infuse IV over 15-30 minutes once *****MAXIMUM DOSE OF 1000mg for all weight based dosing*****

Patient Weight: _____ kg or _____ lb Patient Height: _____ in

OPTIONAL PREMEDICATIONS and LAB ORDERS
☐ Acetaminophen 650mg PO prior to infusion
☐ Diphenhydramine 25mg PO or IV (per patient preference) prior to infusion
☐ Methylprednisolone 40mg slow IVP prior to infusion
☐ Other PreMed and Lab Order with frequency:_____

In the event of an infusion reaction or adverse event, our covering physician will be notified and appropriate medical care will be administered.

PRESCRIBER INFORMATION		
Prescriber Name:	NPI:	Contact:
Phone:	Fax:	Email:
Prescriber Signature:		Date:

Contact us with questions at: 804-442-3558 or email referrals@theinfusionsolution.com
Fax completed form and ALL required documentation to 804-554-5848
All information contained in this form is strictly confidential and will become part of the patient's record.