MONOFERRIC INFUSION ORDER

Date: ____/____/_____

PATIENT INFORMATION

Patient Name:_____ DOB:___/____/____ Phone: _____

Height: _____ Weight(Required):_____ lbs/kg

Allergies: _____

MEDICAL INFORMATION

ICD-10 & Diagnosis:

- ☐ D50.0: Iron deficiency anemia secondary to blood loss (Chronic)
- ☐ E61.1: Unspecified Iron Deficiency
- ☐ Other: _____

MONOFERRIC THERAPY ORDER

*Patient must try and fail Venofer or provide letter of Medical Necessity

- ☐ Pateint weighing less than 110lbs/50kg: 20mg/kg x 1 Year
- ☐ Patient weighing more than 110lbs/50kg: 1000mg IV x 1 Year

Start Date of Infusion: ___/___/___ End Date: ___/___/___

PROVIDER INFORMATION

Provider's Name: _____

Provider's NPI: _____ Signature: _____

Phone: _____ Fax: _____ Date: _____/_____/_____

Office Address: _____

Email Address: _____ Contact Person: _____

PLEASE FAX COMPLETED FORM, CLINICAL DOCUMENTATION, DEMOGRAPHICS & COPY OF INSURANCE CARD

PHONE: 972-810-0990 | FAX: 972-810-0994