ALLIED PHARMACY
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**QUESTIONS?** Please contact us!
www.alliedscripts.com

# Iron Referral Form

Date Medication Needed: _____ Ship To: (○) Patient's Home (○) Prescriber's Office (○) Pick-up (store location): _____ Injection training by pharmacy? ☐

## 1. Patient Information | Insurance Information

Please include copies of the FRONT and BACK of ALL insurance cards (prescription and medical) with this fax.

Patient Name: _____ Birth Date: _____ Sex: (○) Male (○) Female Height: _____ Weight: _____ ( ) lbs. ( ) kg.
Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____
Address: _____ City: _____ State: _____ Zip: _____
Alternate Caregiver Name: _____ Preferred Phone: _____

## 2. Prescriber Information

Provider Name: _____ Specialty: _____ DEA#: _____ NPI#: _____ Tax ID#: _____
Address: _____ Phone: _____ Fax: _____
City, State, Zip: _____ Key Contact: _____ Phone: _____

## 3. Diagnosis/Clinical Information

Please FAX recent clinical notes, labs, tests, with the prescription to expedite the prior authorization.

**Diagnosis:** IRON Replacement Therapy (○) Yes (○) No **Pregnancy:** (○) Yes (○) No **Breast Feeding:** (○) Yes (○) No
**Failed prior therapy:** (○) Yes (○) No Indicate: _____
**Allergy:** _____ **Latex:** (○) Yes (○) No
**Provided by:** ☐ Doctor's Office ☐ Caregiver ☐ Patient **Training Required:** (○) Yes (○) No **Notes:** _____

## 4. Prescription Information

| Drug Name | Strength | Dose / Frequency / Route | Refill |
|---|---|---|---|
| ☐ **Feraheme® (ferumoxytol)** | ☐ 510mg | ☐ Two-dose regimen: Infuse IV over 30 minutes once, followed by a second IV dose over 30 minutes 3-8 days later.<br>*Administer while patient is in reclined or semi-reclined position**Observe patient for 30 minutes after completion of infusion. | |
| ☐ **Injectafer® (ferric carboxymaltose)** | ☐ ≥50kg: 750mg<br>☐ <50kg: 15mg/kg (_____mg) | ☐ Two-dose regimen: Infuse IV over 15 minutes once, followed by a second IV dose over 15 minutes 7 days later.<br>*Dilute in no more than 250ml 0.9% sodium chloride | |
| ☐ **Venofer® (iron sucrose)** | ☐ 100 mg<br>☐ 200 mg<br>☐ 300 mg<br>☐ 400 mg<br>☐ 500 mg | ☐ Infuse 100mg IV over 15 minutes<br>☐ Infuse 200mg IV over 15 minutes<br>☐ Infuse 300mg IV over 1.5 hours<br>☐ Infuse 400mg IV over 2.5 hours<br>☐ Infuse 500mg IV over 3.5 to 4 hours<br>**Frequency:**<br>☐ 5 doses over a 14 day period<br>☐ every _____ days for _____ doses | |
| ☐ **Monoferric® (ferric derisomaltose)** | ☐ **≥50kg: 1000mg**<br>☐ **<50kg: 20mg/kg (_____ mg)** | ☐ Infuse IV over 30 minutes x 1 dose. | |
| ☐ **INFed® (iron dextran)** | ☐ **100mg**<br>☐ _____ **mg** | ☐ TEST Dose: 25mg IV over 30 seconds x 1 dose. Observe for 1 hour before administering remainder of therapeutic dose.<br>☐ Infuse 100mg IV over 60 minutes every ____ day for a total of _____ doses.<br>☐ Infuse IV over ____ hours (range 4-6 hours) x 1 dose.<br>*Maximum dose = 1000mg* | |
| ☐ **Other** | | | |

## 5. Prescriber Signature

Prescriber, please sign and date below

*By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to RE Pharmacy to act as the prescriber's agent to begin and execute prior authorization process and to help patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.*

**Dispense as written** **Date** **Substitution Permissible** **Date**

**IMPORTANT NOTICE:** This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. In no event should such material be read or retained by anyone other than the named addressee, except by express authorization of the sender to the named addressee.

**# of Prescriptions:** _____

*Faxed prescriptions will only be accepted from a prescribing practitioner.*