○ New Prescription/Referral
○ Prescription Refill

INJECTAFER

Rx:

Patient Name:

DOB:

MEDICATION/Strength: **INJECTAFER**

☐ **1st Dose**: 750mg IV infusion in no more than 250ml of 0.9% NaCl over at least 15 mins

☐ **2nd Dose**: 7 days after the 1st dose, 750mg IV infusion in no more than 250ml of 0.9% NaCl over at least 15 mins or slow IV push over 7.5 mins

☐ **OTHERS:**

Dx: ☐ Iron Deficiency Anemia (D50.9) ☐ **OTHERS (Dx + ICD Code 10)**:

Pre-Medication:

- ☐ Solumedrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Others:
- ☐ Tylenol _____mg PO — ☐ 650mg ☐ 975mg
- ☐ Benadryl _____mg — ☐ 25mg ☐ 50mg — ☐ IV ☐ PO

ANA Kit Protocol:

☐ OK to use

NPI#:

DEA#:

Physician Signature

Date: (Valid for 1 year)

PHYSICIAN INFORMATION

Physician Name:

CLINIC:

Contact Information:

Phone:

Fax:

Email:

Other:

Office Mailing Address:

Check that the following are included:

- ☐ **Patient demographics & Insurance attached**
- ☐ **Clinical progress notes**
- ☐ **History and Physical**
- ☐ **Lab Results**
- ☐ **Other Test Results**
- ☐ **Diagnosis (supporting)**
- ☐ **Medication List**