Injectafer Infusion Order

LivWell INFUSIONS

Fax 888 511-7654 Phone 888 864-7341

Patient Name: _____ **DOB:** _____

Patient Phone: _____ **SEX:** M ◯ F ◯

Please Attach All Insurance Information, front and back

MEDICAL INFORMATION

Diagnosis:

- ☐ D50.0 Iron Deficiency Anemia Secondary To Blood Loss
- ☐ D50.1 Sideropenic Dysphagia
- ☐ D50.8 Other iron deficiency anemias
- ☐ D50.9 Iron Deficiency Anemia, unspecified
- ☐ E61.1 Iron Deficiency (excludes iron deficiency anemia)
- ☐ Other _____

ICD-10 :_____

Patients weight: _____

Lab Date: _____

Allergies: _____

ALSO INCLUDE...

- ◯ Clinical/ Progress Notes
- ◯ Demographics Sheet
- ◯ Current Medications
- ◯ Labs

INJECTAFER ORDER

Patients Weight: _____ kg

Injectafer Dose:

- ◯ 750mg IV - Give 2 doses at least 7 days apart not to exceed 1500mg - **if patient weighing 50kg (110lbs) or greater**
- ◯ 15mg/kg IV - Give 2 doses at least 7 days apart not to exceed 1500mg - **if patient weighing less than 50kg (110lbs)**

Patient is currently taking Oral Iron ☐ YES ☐ NO

Date of last Injectafer Infusion: _____

Additional Comments:

PHYSICIAN INFORMATION

Referring Physician: _____ **Phone:** _____

Practice Address: _____

Office Contact: _____ **Fax:** _____

NPI/ TIN: _____

Referring Physician's Signature_____ **Date:** _____