INJECTAFER (ferric carboxymaltose) Referral Order Form Fax 888.615.1445

Precisionhc

clinically advanced infusion care

WWW.PRECISIONHC.COM

Phone: 615.367.1444 FAX: 888.615.1445

☐ New Referral ☐ Restart ☐ Medication/ Order Change (New Order Required) ☐ Benefits Verification Only ☐ Refill / Renewal

Precision Healthcare can accept only original prescription drug orders from patients, and faxed prescriptions from the prescribing practitioners.

PATIENT INFORMATION

Name: _____

DOB: _____ SS# _____

Phone # _____

Email: _____

PHYSICIAN INFORMATION

Referring Physician: _____

Practice Address: _____

_____

Office Contact: _____

Contact Phone # _____ Contact Fax # _____

NPI / TIN: _____ _____

INJECTAFER MEDICATION ORDERS

Patient Weight: _____ **kg**

DOSING:

☐ Injectafer 15 mg/kg IV – Give 2 doses at least 7 days apart not to exceed 1500 mg – if patient weighing less than 50 kg (110 lbs)

☐ Injectafer 750 mg IV – Give 2 doses at least 7 days apart not to exceed 1500 mg – if patient weighing 50 kg (110lbs) or greater

INDICATION/DIAGNOSIS (required)

***ICD-10 Code/Description** _____

***ICD-10 Code/Description** _____

_____ _____

Referring Physician's Signature Date

May use Precision Allergy Reaction Protocol

LAB ORDERS FOR PRECISION NURSING TO DRAW (please specify)

Orders: _____

Frequency: _____

NOTES (ADDITIONAL INFO OR ORDERS)

REQUIRED DOCUMENTATION

☐ Recent Office notes (along w/ any therapies tried and outcomes) ☐ Current Medication List ☐ History and Physical Report

☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet ☐ Allergies

ATTACH REQUIRED LAB RESULTS (For New Referrals Only)

☐ CBC ☐ Iron panel

APPOINTMENT DATE AND TIME: _____

FOR OFFICE USE ONLY