INJECTAFER (for Heart Failure)

(ferric carboxymaltose)

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:________________lbs or ____________kg	Patient's Email:

REQUIRED DOCUMENTATION

• Insurance Card • History & Physical • Patient Demographics • Most Recent Labs • Medication List

• Recent Iron Panel / H&H Intolerance or unsatisfactory response to oral iron supplementation

PRIMARY AND SECONDARY DIAGNOSIS

Primary Diagnosis:

☐ I09.81 Rheumatic heart failure
☐ I50 Heart failure
☐ I50.9 Heart failure, unspecified
☐ Other:____

Secondary Diagnosis:

☐ D50.0 Iron deficiency anemia secondary to blood loss (chronic)
☐ D50.8 Other iron deficiency anemias
☐ D50.9 Iron deficiency anemia, unspecified
☐ D64.9 Anemia, unspecified
☐ Other:____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: ____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for Injectafer

☐ Provider Prescribed: ____

PRIMARY MEDICATION ORDER

If Weight is <70kg (<154lbs):

☐ Hgb <10: Injectafer 1000mg IV on Day 1 and 500mg IV on Week 6
☐ Hgb 10-13.9: Injectafer 1000mg IV on Day 1 only
☐ Hgb 14-15: Injectafer 500mg IV on Day 1 only

If Weight is ≥70kg (≥154lbs):

☐ Hgb <10: Injectafer 1000mg IV on Day 1 and 1000mg IV on Week 6
☐ Hgb 10-13.9: Injectafer 1000mg IV on Day 1 and 500mg IV on Week 6
☐ Hgb 14-15: Injectafer 500mg IV on Day 1 only

☐ Other:____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted:________________________

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)

☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)

☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

____ ____________________

Provider Signature Date

FAX: (888) 219-8102 | EMAIL: orders@flexcareinfusion.com | VISIT: flexcareinfusion.com/referrals

REVISED 02/24