Heartland Infusion Pharmacy

Phone: (865) 862 - 4557 www.heartlandinfusion.com Fax: (865) 862 – 4556
Alt. Fax: (865) 867 - 7081

Injectafer Order Form

Please fax completed form with patient demographic information, front and back of insurance card (s), recent lab results, and recent office visit notes supporting diagnosis to (865) 862-4556.

Referral Status: ☐ New referral ☐ Dose or frequency change ☐ Order Renewal

PATIENT INFORMATION

Name:

Home Phone: Cell Phone:

Email: Last four Social Security number

DOB: Height: Weight:

Allergies:

ICD-10 Diagnosis Code: Years with Disease:

TB Test (Circle One): Skin Quantiferon Chest Xray Result: Date:

LABORATORY ORDERS

☐ CBC w/ Diff	☐ each infusion	☐ Other	
☐ CRP	☐ each infusion	☐ Other	
☐ CMP	☐ each infusion	☐ Other	
☐ ESR	☐ each infusion	☐ Other	
☐ Hepatic Panel	☐ each infusion	☐ Other	
☐ Renal Panel	☐ each infusion	☐ Other	
☐ Quantiferon TB (annually)		Due:	
☐ Other			

Therapy Orders

☐ Under 50 kgs: Administer 15mg/kg Injectafer (ferric carboxymaltose) IV over 2 doses, at least 7 days apart

☐ Over 50 kgs: Administer 750mg Injectafer (ferric carboxymaltose) IV over 2 doses, at least 7 days apart; total dose 1500mg.

☐ Nursing per Heartland Nursing Procedures (incl reaction management)

☐ **Pre-Medications** ☐ No routine pre-medications required

☐ Tylenol (acetaminophen) _____ mg PO ☐ Zyrtec (cetirizine) 10 mg PO

☐ Solu-Medrol (methylprednisolone) _____mg IV ☐ Claritin (loratadine) 10 mg PO

☐ Benadryl (diphenhydramine) _____mg ☐ PO ☐ IV

☐ Other: _____

PHYSICIAN INFORMATION

Physician's Name:

License #: NPI#: DEA#:

Address:

City: State: Zip:

Office Contact: Email:

Office Phone: Office Fax:

Physician Signature: _____ Date: _____

Patient is being referred to: ☐ Knoxville ☐ Morristown ☐ Kingsport