MedRX Infusion
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Iron Infusion Referral Form

Administer At: Patien's Home Prescriber's Office Other:__________ Hold shipment until notified by prescriber Anticipated Start Date: __________

1. Patient Information

Last Name:

First Name:__________

Date of Birth:__________ Phone:__________

Address:__________

City:__________ State:__________ Zip:__________

2. Prescriber Information

Prescriber Name:__________

Address:__________

City:__________ State:__________ Zip:__________

Phone:__________ Fax:__________

NPI# __________ Office Contact:__________

3. Diagnosis and Clinical Information (Please fax recent clinical notes, labs and tests, with the prescription to expedite the prior authorization)

Allergies:__________ Height:__________ Weight:__________

Tried/Failed Meds and Therapies: __________

Diagnosis (ICD 10 Code):__________

4. Prescription Information

DAW1- Dispense as written. Do not substitute for generic

Drug	Dose and Directions	Qty	Refill
Feraheme 510mg vial	Single-dose regimen: IV: 1.02 g as a single dose Two-dose regimen: IV: 510 mg once; after 3 to 8 days, administer a second dose of 510 mg once.	Dispense QS	
Ferrlecit or Generic: sodium ferric gluconate/sucrose Available as 62.5mg/5ml vial	________ mg: IV once every ______ day For total of #_______ doses Other schedule __________	Dispense QS	
INFeD Available as 100mg/2ml	________ mg: IV once every ______ day For total of #_______ doses Other schedule __________	Dispense QS	
Injectafer Available as 100mg and 750mg	For patients ≥50 kg: Two-dose regimen: IV: 750 mg once; after ≥7 days, administer a second dose of 750 mg once; Single-dose regimen: IV: 15 mg/kg as a single dose; maximum dose: 1 g. For patients <50 kg: IV: 15 mg/kg once; after ≥7 days, administer a second dose of 15 mg/kg once.	Dispense QS	
Monoferric 1000mg/10ml	≥50 kg: 1 g as a single dose 3 doses of 500 mg administered over 7 days <50 kg: 20 mg/kg as a single dose.	Dispense QS	
Venofer Available as 100mg/5ml and 200mg/10ml	________ mg: IV once every ______ day For total of #_______ doses Other schedule __________ *note doses <200 mg can be given as slow IV push	Dispense QS	
Other			

Order will include as needed: Anaphylaxis kit, Diluents, Flushes, Supplies. Skilled Home Health nursing services if administered at home

Prescriber Authorization (No stamps. Signature and date must be completed in prescriber's handwriting)

I authorize MedRX Infusion Clinical Pharmacy to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans.

Prescriber Signature PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. __________ Date __________