MIC | METRO INFUSION CENTER

INFUSION ORDERS- INJECTAFER (FERRIC CARBOXYMALTOSE)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS
☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)
Preferred Location*:

*List of infusion center locations may be found at: https://metroinfusioncenter.com/infusion-center-locations/
Please note: Requests will be accommodated based on infusion center availability and are not guaranteed.

DIAGNOSIS AND ICD 10 CODE	
☐ Iron Deficiency Anemia	ICD 10 Code: D50.9
☐ Iron Deficiency due to Blood Loss	ICD10 Code: D50.0
☐ Other: ____	ICD10 Code: _________________________
Is your patient unable to tolerate, or had inadequate response to oral iron supplements?	☐ YES ☐ NO

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider	☐ Clinical/Progress notes
☐ Patient demographics AND insurance information	☐ Labs and Tests supporting primary diagnosis
☐ CBC and Iron Panel	

MEDICATION ORDERS	
Dosing	☐ Injectafer 750mg IV weekly for 2 doses ☐ Injectafer 750mg IV ______________________________________ *It is recommended that doses are separated by 7 days.* *Patients will be monitored during infusion and for 30 minutes after, unless otherwise specified. Our on-call provider will manage infusion related reactions, in the event that a reaction occurs.*
Refills:	☐ _____ doses

PHYSICIAN INFORMATION		
Prescribing Physician:		
Office Phone:	Office Fax:	Office Email:
Physician Signature:		Date:

Fax referral to (866) 507-1164 or email to MICreferral@metroinfusioncenter.com

All information contained in this form is strictly confidential and will become part of the patient's medical record.

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