PARAGON
INFUSION CENTERS

IRON ORDER FORM

P: 877.365.5566 | F: 855.889.2946

PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: ____________________ DOB: ____________ Phone: ______________

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)

MEDICAL INFORMATION

Patient Weight: ________ Allergies: ______________________________

Primary ICD-10: ______________

- ☐ Iron Deficiency Anemia
- ☐ Iron Deficiency Unspecified
- ☐ Iron Deficiency Anemia secondary to Inadequate Dietary Iron Intake
- ☐ Other medical necessity: ______________

Secondary ICD-10: __________

- ☐ Adverse effect of other drug *(oral iron intolerance or not adequate)*
- ☐ End-stage Renal Disease
- ☐ Intestinal Malabsorption
- ☐ Chronic Kidney Disease
- ☐ Other medical necessity: ______________

☐ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached

☐ Recent Labs: CBC, Ferritin, Iron Studies

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: ______________________________

VENOFER ORDERS

- ☐ Venofer 200mg IV q 3 weeks x 5 doses
- ☐ Venofer 100mg IV q week x 7 weeks then every other week x 7 weeks (10 doses total)
- ☐ Venofer 200mg IV - Administer 5 doses over a 14 day period
- ☐ Venofer 200mg IV weekly x 5 weeks
- ☐ Other: ______________________________

INJECTAFER ORDERS

****If the patient has Aetna, Cigna, Humana, or UHC, the patient must try and fail Venofer first****

☐ **Patient weighing less than 50kg (110 lbs.)**
Dose: Injectafer 15mg/kg IV
Frequency: Give 2 doses at least 7 days apart not to exceed 1500mg

☐ **Patient weighing 50kg (110 lbs.) or greater**
Dose: Injectafer 750mg IV
Frequency: Give 2 doses at least 7 days apart not to exceed 1500mg

MONOFERRIC ORDERS

****If the patient has Aetna, Cigna, Humana, or UHC, the patient must try and fail Venofer first****

☐ **Patient weighing less than 50kg (110 lbs.)**
Dose: Monoferric 20mg/kg IV X 1 dose

☐ **Patient weighing 50kg (110 lbs.) or greater**
Dose: Monoferric 1000mg IV X 1 dose

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing *Paragon Healthcare, Inc*. and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: ______________ Physician Name: ______________ Date: ________

Phone: ______________ Fax: ______________ Contact Person: ______________

INFUSION CENTER LOCATIONS

☐ Alpharetta, GA ☐ Arlington, TX ☐ Atlanta, GA ☐ Austin, TX ☐ Bee Cave, TX ☐ Birmingham, AL ☐ Cape Coral, FL ☐ Clear Lake, TX ☐ Clearwater, FL ☐ Coppell, TX ☐ Creve Coeur, MO ☐ Dallas, TX ☐ Decatur, GA ☐ Denver, CO ☐ El Paso East, TX ☐ El Paso West, TX ☐ Fort Myers, FL ☐ Fort Worth, TX ☐ Hendersonville, TN ☐ Houston, TX ☐ Huntsville, AL ☐ Independence, MI ☐ Kansas City, MI ☐ Knoxville, TN ☐ Kyle, TX ☐ Lubbock, TX ☐ Montgomery, AL ☐ Murfreesboro, TN ☐ Naples, FL ☐ Nashville, TN ☐ North Hills, TX ☐ Plano, TX ☐ Round Rock, TX ☐ San Antonio, TX ☐ Sarasota, FL ☐ Smyrna, GA ☐ St. Louis, MI ☐ Stone Oak, TX ☐ Waco, TX ☐ West Houston, TX ☐ The Woodlands, TX ☐ Other: ______________

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