

IRON INFUSION ORDERS

P: 877.365.5566 | **F:** 855.889.2946

PATIENT INFORMATION:	Fax completed form, insura	nce information, and clinica	al documentation to 855.889.2946
Patient Name:			Phone:
Patient Status: ☐ New to Therapy	☐ Continuing Therapy	Next Treatment Dat	
MEDICAL INFORMATION			
Patient Weight: lbs. (required) Allei	rgies:		
Primary ICD-10:	Second	dary ICD-10:	(Medicare required)
Medicare will not cover ICD-10 D50.9		End-stage Renal Disease	☐ Intestinal Malabsorption
☐ Iron Deficiency Anemia		Chronic Kidney Disease	☐ Iron Deficiency in heart failure
☐ Iron Deficiency Anemia s/t inadequate □	_		g (oral iron intolerance or not adequate)
Other medical necessity:		Other medical necessity:	
VENOFER THERAPY ORDER			
_	au a 14 alass a ani a al		
☐ Venofer 200mg IV - Administer 5 doses ov ☐ Venofer 200mg IV weekly x 5 weeks	er a 14 day period		
Other:			
INJECTAFER THERAPY ORDE			
If the patient has Aetna, Cigna, Humana, or		I fail Venofer first or have	a letter of medical necessity
☐ Patient weighing less than 50kg (110 lbs.)		ent weighing 50kg (110 lbs	•
Dose: Injectafer 15mg/kg IV	Dos	e: Injectafer 750mg IV	
Sig: Give 2 doses at least 7 days apart not to			s apart not to exceed 1500mg
Heart failure dosing (standard) - please inc			1 1
Day 1 dose: ☐ 500mg ☐ 1000mg Week 6 dose: ☐ 500mg ☐ 1000mg			veek 12, 24 and 36 if ferritin
Week 6 dose: I I suuma - I I iuuuma			
ser a date. In sooning In looking	- -	tin 100-300 ng/mL with transferring required prior to	
	- -	transferrin required prior to	
Heart failure dosing (other, specify):	**Serum ferritin and	transferrin required prior to	each maintenance dose
☐ Heart failure dosing (other, specify):	**Serum ferritin and	transferrin required prior to	each maintenance dose
_	**Serum ferritin and	transferrin required prior to	o each maintenance dose
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COMPREHENSIVE SUPPORT FOR IRON THERAPY

PATIENT INFORMATION:
Patient Name: DOB:
REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL
☐ Include signed and completed order (MD/prescriber to complete page 1)
\square Include patient demographic information and insurance information
☐ Include patient's medication list
☐ Supporting clinical notes (H&P) to support primary diagnosis
\square Does the patient have an intolerance, contraindication, or documented tried and
failed use of oral iron? Yes No
\square Does the patient have an intolerance or documented tried and failed use of an IV
iron product? Tes No If yes, which drug(s)?
☐ Labs showing iron deficiency anemia attached
Other medical necessity:
REQUIRED PRE-SCREENING
☐ Labs indicating iron deficiency anemia - please attach

Paragon Healthcare will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (855) 889-2946 or call (877) 365-5566 for assistance