A Carelon Company

IRON ORDER SET

P: 877-365-5566 | **F:** 855-889-2946

PATIENT INFORMATION

Fax completed form, insurance information, and clinical documentation to 855-889-2946

Name:		DOB:	Gender: ☐ Female ☐ Male
Address:		City: State:	ZIP:
Phone:	Email:	Height: ☐ inches ☐ cm	Weight: ☐ lbs. ☐ kg
Allergies:			
Diagnosis Code ICD-10 (required):		**Diagnosis Description:**	
Patient Status: ☐ New to Therapy ☐ Continuing Therapy		Next Treatment Date:	

PHYSICIAN INFORMATION

Prescriber Name:		Phone:	Fax:
Office Contact:			Email:
Address:		City: State:	ZIP:
NPI #:	DEA#:		Tax ID:

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Drug	Dosing
Monoferric* (ferric derisomaltose)	☐ 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
Injectafer* (ferric carboxymaltose)	☐ Patient weighing less than 50kg (110 lbs.) Dose: Injectafer 15mg/kg IV Sig: Give 2 doses at least 7 days apart (max 1500mg) ☐ Patient weighing 50kg (110 lbs.) or greater Dose: Injectafer 750mg IV Sig: Give 2 doses at least 7 days apart (max 1500mg)
	Heart failure Injectafer IV dosing (standard) - please indicate initial dose and maintenance dose (if applicable) Day 1 dose: ☐ 500mg ☐ 1000mg Week 6 dose: ☐ 500mg ☐ 1000mg ☐ Administer a maintenance dose of 500mg at week 12, 24 and 36 if ferritin <100 ng/mL or ferritin 100-300 ng/mL with transferrin sat <20% **Serum ferritin and transferrin required prior to each maintenance dose ☐ Other dosing: ________________
Venofer (iron sucrose)	☐ Venofer 200mg IV - Administer 5 doses over a 14 day period ☐ Venofer 200mg IV weekly x 5 weeks ☐ Other: ________________

*If the patient has Aetna, Cigna, Humana, or UHC, the patient must try and fail Venofer first or have a letter of medical necessity
Note: Venofer and Injectafer are given as supplemental therapies only

Other orders: ________________

Lab Orders: ________________ **Lab frequency:** ________
☐ Serum ferritin & transferrin at 12, 24, & 36 weeks (Injectafer in heart failure)
Required labs to be drawn by ☐ Paragon Healthcare ☐ Referring Provider

As required by your state, Prescriber to check “Dispense as written” or handwrite “Brand Medically Necessary” and sign to prevent generic substitution. ☐ Dispense as written

PRESCRIBER SIGNATURE

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, and to select the preferred site of care for the patient.

Prescriber Signature: X **Date:**

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COMPREHENSIVE SUPPORT FOR IRON THERAPY

PATIENT INFORMATION

Name: DOB:

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

❒ Include signed and completed order (MD/prescriber to complete page 1)

❒ Include patient demographic information and insurance information

❒ Include patient's medication list

❒ Supporting clinical notes (H&P) to support primary diagnosis

- ❒ Does the patient have an intolerance, contraindication, or documented tried and failed use of oral iron? ❒Yes ❒No
- ❒ Does the patient have an intolerance or documented tried and failed use of an IV iron product? ❒Yes ❒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**