AYSA
THERAPEUTICS INFUSION

IRON ORDER FORM

P: 470.395.6076 | F: 470.745.0716

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 *At Your Service Anesthesia, 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: _____