Oregon Specialty Infusion
A Practice of Oregon Specialty Group

Specialty Order Form

Patient: _____	Ordering Provider: _____
DOB: _____ ☐ M ☐ F	NPI: _____
Height: _____ Weight: _____ lbs.	Practice: _____
Allergies: _____	Phone: _____
Diagnosis: _____	Fax: _____
ICD-10 Code(s): _____	Contact Name: _____

Has the patient been treated for this condition previously? ☐ No ☐ Yes, medication(s): _____

Is the patient currently on therapy? ☐ No ☐ Yes, medication(s): _____

☐ **INJECTAFER (FERRIC CARBOXYMALTOSE)** 750 mg IV for a total of 2 infusions at least 7 days apart.

☐ **VENOFER (IRON SUCROSE)**

- ☐ 200 mg IV for a total of 5 infusions over 2 weeks (with at least 1 day between each infusion).
- ☐ Alternative Dosage: _____

Quick Checklist for referring Injectafer and Venofer patients.

- ☐ Include demographic sheet and copy of insurance card(s).
- ☐ Completed Oregon Specialty Infusion Specialty Order
- ☐ Form Signed RX
- ☐ Recent Progress Note
- ☐ Ferritin levels within 30 days

Physician's Signature: _____ **Date:** _____