Injectafer (ferric carboxymaltose) Order Form

Oregon Specialty Infusion
A Practice of Oregon Specialty Group

Demographics

Patient Name: _____ Ordering Provider: _____

DOB: _____ NPI: _____

Phone Number: _____ Primary Care Provider: _____

Allergies: _____ Insurance Information: _____

Referral Status

☐ Is your patient currently on or have they failed oral iron?

☐ No, if oral iron was never tried and or failed, this will need to be ordered for 3 months. ☐ Yes, medication(s):_____

If yes, did they have an unsatisfactory response?

☐ Intolerant, Describe reaction: _____

☐ Other _____

Diagnosis & Required Information

Diagnosis and ICD 10 Code(s):

☐ Iron deficiency anemia D50. 9

☐ Anemia in chronic kidney disease D63.1

☐ Sideropenic dysphagia D50.1

☐ Other iron deficiency anemias D50.8

☐ Iron deficiency due to blood loss D50.0 (If selected please list secondary diagnosis code)

Please include the following along with the order form:

☐ Patient face sheet

☐ CBC and iron panel results *(Must be within 28-days of scheduled treatment)*

☐ Provider notes that include supporting diagnosis

Secondary Diagnosis, *please select one of the options below:*

☐ Excessive, frequent, and irregular menstruation N92___

☐ Gastrointestinal hemorrhage, unspecified K92.2

☐ Hemorrhage, not elsewhere classified R58

☐ ***Other diagnosis (Heart failure for Injectafer ONLY): _____

Medication Order

Drug: Injectafer (ferric carboxymaltose) For prescribing information visit: INJECTAFER® (ferric carboxymaltose injection) | IV Iron Treatment

☐ IV 750 mg weekly for 2 doses

☐ IV 750 mg: _____

☐Other: _____

Labs:

☐ Complete Metabolic Panel, routine, ONCE every _____ ☐ Days ☐ Weeks ☐ Months

☐ CBC with Differential, routine, ONCE every _____ ☐ Days ☐ Weeks ☐ Months

(Re-draw CBC if out of the allowed 28-day reference period)

☐ Other: _____

OSI hypersensitivity protocol: Solumedrol, Benadryl, or Famotidine, NS could be used in the event of a hypersensitivity reaction. Referring office will be notified if this occurs

Physician's Signature: _____ Date: _____

Provider Name: _____ Office Phone: _____ Office Fax: _____

Fax completed form to (503) 540-3105

Questions? Call us at (503) 540-9999

Updated 5/2025