Specialty Infusion Services

INJECTAFER (FERRIC CARBOXYMALTOSE) REFERRAL ORDER FORM

This form is available online at: https://osohomecare.com/make-a-referral

☐ New Referral ☐ Medication/Order Change (New Order Required) ☐ Restart ☐ Benefits Verification Only

PATIENT INFORMATION

Name:_____ DOB:_____ SS #:_____

Home Phone:_____ Other Phone:_____ Email:_____

Allergies:_____ Insurance Info:_____

PHYSICIAN INFORMATION

Referring Physician:_____

Practice Address:_____

Office Contact:_____

Phone:_____ Fax:_____ NPI#:_____

INJECTAFER (FERRIC CARBOXYMALTOSE) MEDICATION ORDERS

Patient Weight:_____ kg

DOSING:

☐ **Patient weight less than 50kg (110 lbs):** Injectafer 15 mg/kg IV - Give 2 doses at least 7 days apart not to exceed 1500 mg

☐ **Patient weight 50kg (110 lbs) or greater:** Injectafer 750 mg IV - Give 2 doses at least 7 days apart not to exceed 1500 mg

INDICATION/DIAGNOSIS - Primary Diagnosis

☐ D50.9 Iron Deficiency Anemia, unspecified

☐ D50.8 Other iron deficiency anemias

☐ Patient has had intolerance to oral iron or unsatisfactory response to oral iron

☐ Patient has non-dialysis dependent CKD

☐ Other Medical Necessity:_____

***ICD-10 _____ required**

PLEASE NOTE: Injectafer prescriptions require a primary ICD-10-CM code for IDA as well as a secondary ICD-10-CM code for the underlying condition causing IDA.

Referring Physician's Signature:_____ Date:_____

NOTES

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REQUIRED DOCUMENTATION

☐ Demographic Sheet

☐ Insurance Cards (front and back)

☐ Lab Results

☐ History and Physical Report (w/in past 6 months)

☐ Current Medication List

☐ Recent Office Notes (along with any therapies tried and outcomes)

Oso Specialty Infusion

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