INJECTAFER (FERRIC CARBOXY MALTOSE INJECTION) Referral Order Form **FAX (855) 891-2191**

Effective: 5/2017

MPP Infusion Centers

www.mppinfusion.com

Referral Phone: (855) 478-1528 Referral Fax: (855) 891-2191

☐ Denver ☐ Arlington ☐ Dallas ☐ Duncanville ☐ Irving ☐ Lewisville ☐ Plano ☐ Southlake

☐ New Referral ☐ Restart ☐ Medication/ Order Change *(New Order Required)* ☐ Benefits Verification Only ☐ D/C Infusions *indicate name of drug(s)

_____

PATIENT INFORMATION

Name: _____ Date: _____

DOB: _____ SS# _____

Phone # _____

Email: _____

PHYSICIAN INFORMATION

Referring Physician: _____

Practice Name: _____

Specialty: _____

Office Contact: _____

Contact Phone # _____ Contact Fax # _____

Contact Email: _____

INJECTAFER MEDICATION ORDERS

Patient Weight: _____kg

☐ Dosing: 750 mg IV on day 0 and day 7 or greater.

☐ Dosing: 15 mg/kg IV on day 0 and day 7 or greater.

INDICATION/DIAGNOSIS

☐ Iron Deficiency Anemia

Primary ICD-10_____**required**
Secondary ICD-10 for underlying condition causing IDA_____

NOTES (ADDITIONAL INFO)

_____ _____

Referring Physician's Signature Date

REQUIRED DOCUMENTATION

☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication List ☐ History and Physical Report (w/in past 6 months)

☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

☐ Ferritin, w/in past 3 months

APPOINTMENT DATE & TIME: _____

FOR OFFICE USE ONLY