



IRON Referral Form

RETURN COMPLETED FORM VIA FAX TO:

888.898.9113

PATIENT INFORMATION (Complete or fax existing chart)	PRESCRIBER INFORMATION
Patient Name: _____	Prescriber Name: _____
Address: _____	State License: _____ NPI #: _____
City, State, Zip: _____	DEA: _____ Phone: _____
Phone: _____ Alt. Phone: _____	Address: _____ Fax: _____
DOB: _____ Gender: M F Last 4 SSN: _____	City, State, Zip: _____
WT: _____ HT: _____ Allergies: _____	Contact Person: _____ Phone: _____

INSURANCE INFORMATION - INSTEAD - just send us a copy of the patient's prescription / insurance cards (front & back)

Primary Insurance: _____	RX Card (PBM): _____
City, State, Zip: _____	BIN: _____ PCN: _____
Plan #: _____	City, State, Zip: _____
Group #: _____	Group #: _____
Phone: _____	Phone: _____

DIAGNOSIS/CLINICAL INFORMATION

<input type="checkbox"/> D 50.9 Iron deficiency anemia	<input type="checkbox"/> Other Code + description: _____
<input type="checkbox"/> LABWORK:	
Serum Ferritin level	TIBC (Iron % binding panel)
CBC	Other

MEDICATION, DOSING AND DIRECTIONS:

MEDICATION	DOSE	DIRECTIONS	REFILLS
INJECTAFER (ferric carboxy-maltose)	<input type="checkbox"/> 750mg IV	Mix in 100ml NS and give over 30 minutes. Observe patient for 30 minutes afterward. Two (2) doses should be at least 5 to 7 days apart	
INFED (Iron dextran)	<input type="checkbox"/> 500mg IV	Give a test dose of 25mg IVP over 30 to 60 sec. Wait 30 minutes. If no reaction, administer the rest of the drug in 500ml NS over two (2) hours	
	<input type="checkbox"/> 1000mg IV		
VENOFER (iron sucrose)	<input type="checkbox"/> 100mg IV	Mix in 100 – 250ml NS. Give over 30 minutes per 100mg of drug. Repeat dose every _____ weeks.	
	<input type="checkbox"/> 200mg IV		
	<input type="checkbox"/> 300mg IV		

SIGNATURE

X _____ DATE: _____

Prescribing Physician Signature

To insure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

Important Information: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee.

Thank you for choosing Talis Healthcare

RETURN COMPLETED FORM VIA FAX TO: 888.898.9113