INJECTAFTER (ferric carboxy-Maltose)

Please Fax Completed Form To: 888-898-9113

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: ________________________________ DOB: _____________
Address: ____
City, State, Zip: ____
Phone: ____________________ Alt. Phone: ____________________
Email: __________________________ SS#: ____________________
Gender: ☐ M ☐ F Weight: ________(lbs) Ht: ________________
Allergies: ____

PRESCRIBER INFORMATION

Prescriber Name: ____
State License: ____
NPI #: _________________ DEA: _____________________________
Address: ____
City, State, Zip: ____
Phone: ______________________ Fax: ________________________
Office Contact: _______________________ Phone: _______________

INSURANCE INFORMATION – OR – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: ____
City, State, Zip: ____
Plan #: ____
Group #: ____
Phone: ____

RX Card (PBM): ____
BIN: _________________________ PCN: ______________________
City, State, Zip: ____
Group #: ____
Phone: ____

CLINICAL INFORMATION

Diagnosis/ ICD 10 Code:

☐ D50.9 Iron deficiency anemia ☐ Other:____________________

Lab work:

Serum Ferritin level: _______________ TIBC (iron % binding panel): _______________ CBC: _______________ Other:_____________________

INJECTAFER ORDERS

Prescription type: ☐ New start ☐ Restart ☐ Continued therapy Total Doses Received: _________ Date of Last Injection/Infusion: ___________

Medication	Directions	Quantity/Refills
☐ Injectafer (ferric carboxy-Maltose) 750mg IV	Mix in 100ml NS and give over 30 minutes. Observe Patient for 30 minutes afterward. 2 doses should be at least 5-7 days apart.	Quantity: ___________________ Refills: _____________________

SIGNATURE

We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X____ Date: ___________________

Prescriber Signature

To ensure 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.