

**PATIENT INFORMATION**
 *Demographics attached*

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

**INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)**
**MEDICAL INFORMATION**

Patient Weight: \_\_\_\_\_ Allergies: \_\_\_\_\_

**Primary ICD-10:** \_\_\_\_\_

- Iron Deficiency Anemia
- Iron Deficiency Unspecified
- Iron Deficiency Anemia secondary to Inadequate Dietary Iron Intake
- Other medical necessity: \_\_\_\_\_

**Secondary ICD-10:** \_\_\_\_\_

- Adverse effect of other drug  
*(oral iron intolerance or not adequate)*
- End-stage Renal Disease
- Intestinal Malabsorption
- Chronic Kidney Disease
- Other medical necessity: \_\_\_\_\_

 Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached

 Recent Labs: CBC, Ferritin, Iron Studies

**Labs:** Required labs to be drawn by:  Infusion Clinic  Referring Physician

**Lab Orders:** \_\_\_\_\_

**VENOFER ORDERS**

- Venofer 200mg IV q 3 weeks x 5 doses  Venofer 100mg IV q week x 7 weeks then every other week x 7 weeks (10 doses total)
- Venofer 200mg IV - Administer 5 doses over a 14 day period  Venofer 200mg IV weekly x 5 weeks
- Other: \_\_\_\_\_

**INJECTAFER ORDERS**
 **Patient weighing less than 50kg (110 lbs.)**

Dose: Injectafer 15mg/kg IV

Frequency: Give 2 doses at least 7 days apart not to exceed 1500mg

 **Patient weighing 50kg (110 lbs.) or greater**

Dose: Injectafer 750mg IV

Frequency: Give 2 doses at least 7 days apart not to exceed 1500mg

**MONOFERRIC ORDERS**
 **Patient weighing less than 50kg (110 lbs.)**

Dose: Monoferic 20mg/kg IV X 1 dose

 **Patient weighing 50kg (110 lbs.) or greater**

Dose: Monoferic 1000mg IV X 1 dose

**PHYSICIAN INFORMATION**

By signing this form and utilizing our services, you are authorizing *Paragon Healthcare, Inc.* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Physician Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Contact Person: \_\_\_\_\_

**INFUSION CENTER LOCATIONS**

<input type="checkbox"/> Alpharetta, GA	<input type="checkbox"/> Arlington, TX	<input type="checkbox"/> Atlanta, GA	<input type="checkbox"/> Austin, TX	<input type="checkbox"/> Clear Lake, TX	<input type="checkbox"/> Dallas, TX	<input type="checkbox"/> Decatur, GA	<input type="checkbox"/> Fort Worth, TX
<input type="checkbox"/> Hendersonville, TN	<input type="checkbox"/> Houston, TX	<input type="checkbox"/> Knoxville, TN	<input type="checkbox"/> Kyle, TX	<input type="checkbox"/> Nashville, TN	<input type="checkbox"/> North Hills, TX	<input type="checkbox"/> Plano, TX	<input type="checkbox"/> Round Rock, TX
<input type="checkbox"/> San Antonio, TX	<input type="checkbox"/> Smyrna, GA	<input type="checkbox"/> Stone Oak, TX	<input type="checkbox"/> West Houston, TX	<input type="checkbox"/> The Woodlands, TX			

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