



IRON INFUSION ORDER FORM
P: 240.200.4464 F: 240.892.3005

PATIENT INFORMATION: Fax completed form, insurance information, and clinical documentation to 240.892.3005

Patient Name: _____ DOB: _____ Phone: _____

MEDICAL INFORMATION

Patient Weight: _____ lbs./kg. (required) Allergies: _____

Primary ICD-10: _____

Secondary ICD-10: _____

- | | |
|---|---|
| <input type="checkbox"/> Iron Deficiency Anemia | <input type="checkbox"/> Adverse effect of other drug (oral iron intolerance or not adequate) |
| <input type="checkbox"/> Iron Deficiency Unspecified | <input type="checkbox"/> End-Stage Renal Disease |
| <input type="checkbox"/> Iron Deficiency Anemia secondary to Inadequate Dietary Iron Intake | <input type="checkbox"/> Intestinal Malabsorption |
| <input type="checkbox"/> Other medical necessity: _____ | <input type="checkbox"/> Chronic Kidney Disease |
| | <input type="checkbox"/> Other medical necessity: _____ |

INFED THERAPY ORDER

- Infed 1000 mg IV** x 1 dose
- Infed _____ mg IV** x 1 dose
- Infed _____ mg/kg IV** x 1 dose

*** Administer 25 mg test dose over at least 30 seconds, wait 1 hour before administering the remaining dose***

INJECTAFER THERAPY ORDER

- | | |
|--|---|
| <input type="checkbox"/> 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 | <input type="checkbox"/> Patient weighing 50kg (110 lbs.) or greater
Dose: Injectafer 750mg IV
Frequency: Give 2 doses at least 7 days apart not to exceed 1500 mg |
|--|---|

MONOFERRIC THERAPY ORDER

- | | |
|--|--|
| <input type="checkbox"/> Patient weighing less than 50kg (110 lbs.)
Dose: Monoferric 20mg/kg IV x 1 dose | <input type="checkbox"/> Patient weighing 50kg (110 lbs.) or greater
Dose: Monoferric 1000mg IV x 1 dose |
|--|--|

Anaphylactic Reaction Orders:

- Epinephrine (based on patient weight)
 - >30 kg (>66lbs.): 0.3mg IM or subQ; may repeat in 5-10 minutes x 1
 - 15-30 kg (33-66lbs.) 0.15mg IM or subQ; may repeat in 5-10 minutes x 1
- Solu-Medrol 125mg IV as needed
- NS 250-500mL IV bolus as needed

Flush Orders: NS 1-20mL pre/post infusion PRN

Please provide patient's demographic information, insurance information, medication list, and clinical notes. Active Infusions will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and assist them in enrolling in any available co-pay assistance programs as needed/applicable. Thank you for the referral.

PROVIDER INFORMATION

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____



COMPREHENSIVE SUPPORT FOR
IRON INFUSION THERAPY
P: 240-200-4464 F: 240-892-3005

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING AND INSURANCE APPROVAL

- Include signed and completed order (MD/prescriber to complete previous page)
- Include patient demographic information and insurance information
- Include patient's medication list
- Supporting clinical notes (H&P) to support primary diagnosis
 - Does the patient have an intolerance, contraindication, or documented tried and failed use of oral iron?
 - Yes No
 - If yes, which drug(s)? _____
 - Does the patient have an intolerance or documented tried and failed use of an IV iron product?
 - Yes No
 - If yes, which drug(s)? _____
- Labs showing iron deficiency anemia attached
- Other medical necessity: _____

REQUIRED PRE-SCREENING

- Labs indicating iron deficiency anemia – please attach**

Please fax all information to 240-892-3005 or email to info@activeinfusions.com for assistance

ACTIVE INFUSIONS | Patient Demographics Request

Dear Provider / Office Staff,

We have received a referral for the above patient and will be reaching out to begin the scheduling process. To ensure we are able to make contact in a timely manner, we kindly ask that your office confirm or complete the patient demographic information below. This helps us verify accurate contact details prior to outreach and avoid any delays in care.

Please complete and return via fax to 240-892-3005 or email kendrick@activeinfusions.com. Thank you!

PATIENT CONTACT INFORMATION

Please confirm or provide the most current contact information you have on file for this patient.

Patient Name

Last, First MI

Date of Birth

MM / DD / YYYY

Primary Phone Number

Best phone number

Alternate Phone Number

Alternate number

Email Address

Patient email address

Patient's Preferred Method of Contact:

Phone Call Text Message Email No Preference

EMERGENCY CONTACT

Required for ALL patients receiving therapy for Alzheimer's Disease

Emergency Contact Name

Full name

Relationship to Patient

e.g. Spouse, Child, Friend

Emergency Contact Phone

Phone number

Emergency Contact Email

Email (if available)

PRIMARY INSURANCE: SUBSCRIBER INFORMATION

Please confirm the subscriber / policy holder information for the patient's primary insurance.

Is the patient the Subscriber / Policy Holder?

Yes No

Subscriber / Policy Holder Name

Full name

Relationship to Patient

e.g. Self, Spouse, Parent

Subscriber Date of Birth

MM / DD / YYYY

Subscriber Member ID

Member ID

Insurance Company

Insurance name

Group Number

Group number

COPAY ASSISTANCE PROGRAM

If the patient is enrolled in a manufacturer copay or patient assistance program, please provide details if available.

Program Name

Program name

Program ID Number

ID number on card

NOTES / ADDITIONAL INFORMATION