

Injectafer Enrollment Form

TwelveStone Health Partners

**Fax Referral To:
(800) 223-4063**



Date: _____
Patient Name: _____
Date of Birth: _____

Direct Phone: (615) 278-3350
Toll Free: (844) 893-0012

PREVIOUS ADMINISTRATION

If YES, please provide the following information:

Last Infusion Date: _____
Next Infusion Date: _____

If NO, please indicate desired location for first dose:

Physician's Office
TwelveStone Infusion Center:
 Canton Chattanooga Knoxville Mount Juliet Murfreesboro
 Other: _____
Desired Start Date: _____

DIAGNOSIS

Description

Iron Deficiency Anemia

ICD-10 Code

D50.9 Other: _____

OTHER REQUIRED DOCUMENTATION (Please attach documents as needed)

This signed order form History and Physical
 Patient Demographics and Insurance Information Clinical progress notes, lab work (including most recent renal function tests and any other tests supporting primary diagnosis)

CLINICAL INFORMATION (Please attach all clinical information, lab results and other medical history documents)

Patient Weight: _____ Kg Height: _____ Inches/CM BSA: _____ Allergies: _____

Line Access: PIV PICC (SL DL TL) PORT (Huber size _____ Gauge _____ Length) Sub-Q

MEDICATION DIRECTIONS REFILLS BASELINE LABWORK REQ'D TO INITIATE (Check for TwelveStone to draw)

<input type="checkbox"/> Injectafer	<input type="checkbox"/> <50kg - Infuse 15mg/kg (____ mg) IV over 15 minutes. Administer 2 doses separated by at least 7 days. (Total - ____mg). Observe for 30 minutes after each infusion.		<input type="checkbox"/> CBC w/Differential <input type="checkbox"/> HGB, HCT, TIBC, Ferritin
	<input type="checkbox"/> = or > 50kg - Infuse 750 mg IV over 15 minutes. Administer 2 doses separated by at least 7 days. (Total - 1500mg). Observe for 30 minutes after each infusion.		

LAB ORDERS - To be drawn by TwelveStone

<u>Order</u>	<u>Frequency</u>
CBC w/Differential	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q ____ Weeks <input type="checkbox"/> Other _____
CBC w/o Differential	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q ____ Weeks <input type="checkbox"/> Other _____
CMP	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q ____ Weeks <input type="checkbox"/> Other _____
BMP	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q ____ Weeks <input type="checkbox"/> Other _____
CRP	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q ____ Weeks <input type="checkbox"/> Other _____
Sed Rate	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q ____ Weeks <input type="checkbox"/> Other _____
Calcium	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q ____ Weeks <input type="checkbox"/> Other _____
Tb QuantiFERON Gold	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q ____ Weeks <input type="checkbox"/> Other _____
Hepatitis Panel	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q ____ Weeks <input type="checkbox"/> Other _____
Other _____	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q ____ Weeks <input type="checkbox"/> Other _____

PRE-MEDICATIONS - *RECOMMENDED/Check Here if NO Pre-Meds _____

<u>Oral</u>	<u>IV</u>
Acetaminophen: <input type="checkbox"/> 325mg <input type="checkbox"/> 500mg <input type="checkbox"/> 650mg	Dexamethasone: <input type="checkbox"/> 10mg
Cetirizine: <input type="checkbox"/> 10mg	Diphenhydramine: <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg
Diphenhydramine: <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg	Famotidine: <input type="checkbox"/> 20mg <input type="checkbox"/> 40mg
Famotidine: <input type="checkbox"/> 20mg <input type="checkbox"/> 40mg	Methylprednisolone: <input type="checkbox"/> ____mg IV over ____ mins
Ibuprofen: <input type="checkbox"/> 200mg	Ondansetron: <input type="checkbox"/> 4mg <input type="checkbox"/> 8mg
Loratadine: <input type="checkbox"/> 10mg	
Ondansetron: <input type="checkbox"/> 4mg	

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

Physician's Phone # _____ Physician's NPI# _____ Physician's Fax # _____ Physician's Address _____
Dispense as Written _____ Date _____ Substitution Allowed _____ Date _____

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