



IV Iron Infusion Referral Form

Home Infusion Prescription & Referral

Patients / caregivers: complete sections 1–2 and give this form to your prescriber. Prescribers: complete sections 3–7, sign, and fax with attachments to 855-872-5872.

Referral type: ☐ New referral ☐ Renewal / re-order ☐ Dose or frequency change ☐ Discontinue therapy Needed by

Administer at: ☐ Patient's home ☐ Prescriber's office ☐ Infusion suite ☐ SNF / other ☐ Hold until notified Start date

1 PATIENT INFORMATION

Last name First name MI Date of birth Sex: ☐ M ☐ F
Street address City State ZIP
Primary phone Alternate phone Email Preferred language
Caregiver / emergency contact Relationship Phone **OK to leave voicemail?** ☐ Yes ☐ No

2 INSURANCE & BILLING INFORMATION

Attach copies of ALL insurance cards, front and back

Primary insurance Member ID Group # Plan phone
Subscriber name Subscriber DOB Relationship to patient Medicare ID (MBI) Medi-Cal CIN
Secondary insurance Member ID Group # Plan phone
Rx card (if separate) Rx ID RxBIN RxPCN RxGroup **Coverage:** ☐ Medicare ☐ Medi-Cal ☐ Commercial / PPO ☐ HMO / IPA
Prior authorization: ☐ Not started — Biologic to obtain ☐ Pending ☐ Obtained Auth # Valid dates IPA / case manager

3 PRESCRIBER & REFERRAL SOURCE

Prescriber name Credentials NPI State license #
Practice / group Phone Fax
Address City State ZIP
Office contact Direct phone / ext Contact email Supervising MD (if NP/PA)
Referral source (if different) Hospital / facility Discharge planner / case manager Phone Discharge date

4 DIAGNOSIS & CLINICAL INFORMATION

Check all that apply — codes below are common indications, not a substitute for the chart

Primary dx ICD-10 Description Secondary dx ICD-10 Description
☐ D50.0 Iron deficiency anemia, blood loss ☐ D63.1 Anemia in chronic kidney disease ☐ K90.0 Celiac disease
☐ D50.8 Other iron deficiency anemia ☐ D63.8 Anemia in other chronic disease ☐ Z98.84 Bariatric surgery status
☐ D50.9 Iron deficiency anemia, unspecified ☐ N18.3– N18.6 CKD stage 3–5 / ESRD ☐ I50.9 Heart failure
☐ E61.1 Iron deficiency without anemia ☐ K50.9- Crohn's disease ☐ O99.01- Anemia complicating pregnancy
☐ D63.0 Anemia in neoplastic disease ☐ K51.9- Ulcerative colitis ☐ O90.81 Anemia of the puerperium

Height in Weight lb / kg Date ☐ NKDA Allergies & reactions

Vascular access: ☐ None — needs placement ☐ Peripheral ☐ Midline ☐ PICC ☐ Port ☐ Tunneled CVC Lumens Date placed

Pregnant? ☐ Yes ☐ No EDD Hgb Ferritin TSAT % Serum iron TIBC Lab date

Oral iron / other therapies tried & failed (product, duration, reason stopped)

Prior IV iron? ☐ No ☐ Yes Product Date of last dose Reaction / tolerance

Please attach: ☐ Face sheet ☐ Insurance cards (front & back) ☐ H&P / progress notes ☐ Medication list

☐ Recent CBC & iron studies (≤ 90 days)

Patient name DOB Prescriber

5 PRESCRIPTION — IV IRON

Check ONE product and complete its regimen. Weight-based doses use the weight on page 1.

☐ Feraheme (ferumoxytol) 510 mg / 17 mL vial	☐ 1,020 mg IV as a single dose ☐ 510 mg IV × 2 doses, 3–8 days apart
☐ Injectafer (ferric carboxymaltose) 750 mg / 15 mL vial	☐ ≥ 50 kg: 750 mg IV × 2, ≥ 7 days apart ☐ ≥ 50 kg: 15 mg/kg IV × 1 (max 1,000 mg) ☐ < 50 kg: 15 mg/kg IV × 2, ≥ 7 days apart Other
☐ Monofer (ferric derisomaltose) 1,000 mg / 10 mL vial	☐ ≥ 50 kg: 1,000 mg IV × 1 ☐ < 50 kg: 20 mg/kg IV × 1 Other
☐ Venofer (iron sucrose) 100 mg / 5 mL, 200 mg / 10 mL vials	mg IV every day(s) × doses Other schedule
☐ Ferrlecit / sodium ferric gluconate 62.5 mg / 5 mL vial	mg IV every day(s) × doses Other schedule
☐ INFeD (iron dextran) 100 mg / 2 mL vial	mg IV every day(s) × doses ☐ 25 mg test dose before first dose
☐ Other product	Product Dose & schedule

Total course / cumulative target dose mg ☐ Repeat course if follow-up labs confirm continued deficiency Special instructions

Venofer / Ferrlecit / INFeD: doses ≤ 200 mg may be given as slow IV push per label; larger doses are diluted in 0.9% NaCl and infused by pump per Biologic protocol. Doses are rounded to the nearest vial unless 'Dispense as written' is selected below.

6 PRE-MEDICATIONS, NURSING & MONITORING

Pre-medications: ☐ None ☐ Acetaminophen 650 mg PO ☐ Diphenhydramine 25 mg PO ☐ Loratadine 10 mg PO ☐ Methylprednisolone 40 mg IV

Other pre-medication (drug, dose, route)

Standing orders included with every referral unless declined: anaphylaxis / hypersensitivity kit per Biologic protocol, 0.9% NaCl diluent and flushes, infusion supplies and pump as needed, ancillary refills × 12 months.

☐ Decline / modify standing orders:

Nursing: ☐ Skilled RN to administer each dose in the home ☐ Observe 30 min post-infusion, vitals per protocol Other

Follow-up labs: ☐ CBC, ferritin, iron / TIBC / TSAT wks after last dose ☐ Phosphorus (Injectafer) ☐ Fax results to prescriber Other

7 PRESCRIBER AUTHORIZATION

Original signature required — no stamps

I certify that the IV iron therapy ordered above is medically necessary, that the patient is under my care, and that I will supervise the patient's treatment. Unless otherwise indicated, orders are valid for 12 months from the date signed. I authorize Biologic Infusion Pharmacy to act as my agent and on behalf of my patient to initiate and complete prior authorization, appeals, and related processes with the patient's health plan(s), including submission of any required forms and clinical documentation. Biologic may release medical information to the patient's health plan(s) and to the home health agency as needed to coordinate care. This authorization may be revoked in writing at any time.

Product selection: ☐ Substitution permitted — Biologic may select product per payer formulary / availability ☐ Dispense as written

Refills x 12 months unless otherwise noted Verbal order taken by / date (pharmacy use)

Prescriber signature (no stamps) Print name & credentials Date

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