Jupiter Infusion
140 Jupiter Lakes Blvd, Suite A
Jupiter, FL 33458
Office: 561-277-9211

IRON INFUSION ORDER FORM
Fax: 561-277-9226

PATIENT INFORMATION: Fax completed form, insurance information, and clinical documentation to 561-277-9226

Patient Name: _____ DOB: _____ Phone: _____

MEDICAL INFORMATION

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

VENOFER THERAPY ORDER

- ☐ Venofer 200mg IV – Administer 5 doses over a 14-day period
- ☐ Venofer 200mg IV weekly x 5 weeks
- ☐ Other: _____

INJECTAFER THERAPY ORDER

****If the patient has Aetna, Cigna, Humana, or UHC, the patient must try and fail Venofer first****

- ☐ **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 THERAPY ORDER

****If the patient has Aetna, Cigna, Humana, or UHC, the patient must try and fail Venofer first****

- ☐ **Patient weighing less than 50kg (110 lbs.)**
  Dose: Monoferric 20mg/kg IV x 1 dose
- ☐ **Patient weighing 50kg (110 lbs.) or greater**
  Dose: Monoferric 1000mg IV x 1 dose

Please provide patient's demographic information, insurance information, medication list, and clinical notes. Jupiter Infusion 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: _____