

MPP Infusion Centers

Fax To: (855) 891-2191

Email To: MPPReferral@mppinfusion.com

Have a Question? Call: (855) 478-1528

A Multispecialty Physician Partner Company

INJECTAFER® (FERRIC CARBOXY MALTOSE INJECTION) ORDER FORM

REFERRAL STATUS

New Referral
 Order Renewal
 Restart
 Medication/Order Change
 Benefits Verification Only

 D/C Infusion (Medication(s) to D/C _____)

LOCATION

Denver
 Arlington
 Dallas
 Duncanville
 Irving
 Lewisville
 Plano
 Southlake
 Tyler

PATIENT INFORMATION

PATIENT NAME: _____ DOB: _____ SEX: MALE FEMALE

ADDRESS: _____ PHONE #: _____

WEIGHT: _____ LBS _____ KG HEIGHT: _____ EMAIL: _____

ALLERGIES: _____

Please check that the following are included	<input type="checkbox"/> Patient demographics and insurance attached	<input type="checkbox"/> Clinical/Progress Notes, H&P, Labs, Tests, supporting DX Attached
	<input type="checkbox"/> Current Medication List	<input type="checkbox"/> Ferritin, w/in the past 3 months

PHYSICIAN INFORMATION

Physician Name: _____ Email (if you would like referral updates): _____

Practice Name: _____ Phone Number: _____

Office Contact: _____ Fax Number: _____

DIAGNOSIS

Iron Deficiency Anemia

Other: _____

ICD-10 CODE: _____ SECONDARY ICD-10: _____ Date of last infusion/injection: _____

MEDICATION ORDERS

INJECTAFER ORDERS:	Notes/Comments
<input type="checkbox"/> Dose: 750 mg IV on day 0 and day 7 or greater (50kg or more)	
<input type="checkbox"/> Dose: 15mg/kg IV on day 0 and day 7 or greater (less than 50kg)	
Physician Signature _____ Date (Order is Valid for One Year) _____ Infusion will be administered per MPP policy and protocol	

STANDING LAB ORDERS

Labs to be Drawn by Infusion Center Frequency: Every Infusion Other (please specify) _____

CMP CBC CRP ESRP HFR UA