MPP INFUSION CENTERS
www.mppinfusion.com

Fax Referrals To: (855) 891-2191
Email Referrals To: MPPReferral@mppinfusion.com
Have a Question? (855) 478-1528

FERAHEME® (ferumoxytol injection) REFERRAL

(- Required Fields)*

_____ **STAT REQUEST**
(*REASON MUST BE PROVIDED BELOW)

_____ **New Referral** _____ **Referral Renewal** _____ **Medication/Order Change**
_____ **Benefits Verification Only** _____ **Discontinuation Order**

PATIENT INFORMATION			
NAME*:		DOB*:	SEX: ☐ M ☐ F
ADDRESS:		PHONE:	
WEIGHT: ☐ LBS ☐ KG	HEIGHT:	EMAIL:	
ALLERGIES:			

PHYSICIAN INFORMATION		
PHYSICIAN NAME*:		PRACTICE NAME:
ADDRESS:		OFFICE CONTACT*:
PHONE:	FAX:	EMAIL *(FOR UPDATES)*:

FERAHEME Infusion*:

*(SELECT **ONE** OF THE FOLLOWING)*

ICD-10*: _____

____ Initial 510 mg dose followed by a second 510 mg dose 3 to 8 days later

Physician Signature* _____
***NPI#**_____

Date*(Order is Valid for One Year) _____
Infusion will be administered per MPP policy and protocols

REQUIRED DIAGNOSIS:

_____ Iron Deficiency Anemia

_____ Chronic Kidney Disease (CKD)

_____ Other_____

Secondary/causal diagnosis code:_____

***STAT REASON:**
(STAT request will be assessed per MP policy and protocol)

REQUIRED DOCUMENTATION CHECKLIST:

_____ Patient Demographics

_____ Insurance Card/Information

_____ Clinical/Progress Notes supporting DX

_____ Current Medication List and H&P

_____ Ferritin, w/in the past 3 months

Last Infusion/Injection Date: _____

STANDING LAB ORDERS (to be drawn at clinic): _____ CMP _____ CBC *Frequency_____

Referral Reviewed and Accepted by: _____ *Date approved:*_____
Additional information needed/ notes:

Locations:

--------Colorado--------
___ Lakewood

---------Florida---------
___ Jacksonville
___ Kissimmee
___ Port St. Lucie
___ Suncoast
___ Winter Park

------Oklahoma--------
___ Tulsa

----------Texas----------
___ Arlington
___ Cedar Hill
___ Dallas
___ Denton
___ Ft. Worth
___ Irving
___ Rockwall
___ Southlake
___ Flowe Mound
___ Plano
___ Tyler

REVISION DATE- 1/2022