AcariaHealth™
Specialty Pharmacy

Phone: 866.892.1580 • Fax: 866.892.2363

Date Shipment Needed: _____ Ship To: ❑Patient ❑Prescriber
❑ Nursing needed; ❑Training needed ▶ All the supplies including syringes and needles will be dispensed if needed.

INJECTAFER REFERRAL FORM

PATIENT INFORMATION					
Patient Name:		DOB:	Sex: ❑M ❑F	Weight:	❑lbs. ❑kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	❑ **Please attach demographic information**		

PRESCRIBER INFORMATION			
Prescriber:	NPI:	DEA:	State Lic:
Supervising Physician:		Practice Name:	
Address:		City:	State:	Zip:
Phone:	Fax:	Key Office Contact:	Phone:

DIAGNOSIS INFORMATION / MEDICAL ASSESMENT

Primary Diagnosis: ❑D50.0 Iron deficiency anemia due to blood loss ❑D50.8 Other Iron deficiency ❑D63.1Anemia in chronic kidney disease ❑Other:_____

- Does the patient have non-dialysis dependent chronic kidney disease? ❑Yes ❑No
- Is the patient currently on dialysis? ❑Yes ❑No
- Does the patient experience an intolerance to an an oral iron or an unsatisfactory response to oral iron? ❑Yes ❑No Medication(s):_____
- Is patient *currently* on therapy? ❑Yes ❑No Medication(s): _____
- Administering as undiluted slow Intravenous Push? ❑Yes ❑No
- Administering as an Infusion? ❑Yes ❑No Infusion supplies: _____

INSURANCE INFORMATION

❑ **Please attach front and back of patient's insurance card (medical and prescription)**

COPAY CARD ENROLLMENT

❑ **Please check if enrolling in copay card** | **Copay ID:**

PRESCRIPTION INFORMATION

❑Injectafer® ferric carboxymaltose injection 750 mg/15 mL

❑<50 kg 15 mg/kg, give Injectafer in 2 doses separated by at least 7 days and each dose as 15 mg/kg body weight, 750 mg/mL vials QTY: _____ Refills:_____

❑>50 kg, give Injectafer in 2 doses of 750 mg doses separated by at least 7 days, 750 mg/mL vials QTY: _____ Refills:_____

**Total cumulative dose not to exceed 1500 mg of iron per course*

❑Infusion Supplies Required

❑Sterile 0.9% Sodium Chlorida, USP, use saline to dilute Injectafer to 2 to 4 mg of iron per mL for infusion (dilute up to 750 mg of iron in no more than 250 mL of strelie 0.9% sodium chloride injection or infusion bag) QTY: 500 mL Refills:_____

❑Other supplies: _____ QTY: _____ Refills:_____

Prescriber's Signature: _____ ❑ DAW (Dispense as Written) **Date:** _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send prescription on official state prescription blank. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.

3.15.19