Specialty Order Form

Patient: ______	Ordering Provider: ______
DOB: ______ ☐ M ☐ F	NPI: ______
Height: ______ Weight: ______ lbs.	Practice: ______
Allergies: ______	Phone: ______
Diagnosis: ______	Fax: ______
ICD-10 Code(s): ______	Contact Name: ______

Has the patient been treated for this condition previously? ☐ No ☐ Yes, medication(s): ______

______

Is the patient currently on therapy? ☐ No ☐ Yes, medication(s): ______

☐ **INJECTAFER (FERRIC CARBOXYMALTOSE)** 750 mg IV for a total of 2 infusions at least 7 days apart.

☐ **VENOFER (IRON SUCROSE)**

- ☐ 200 mg IV for a total of 5 infusions over 2 weeks (with at least 1 day between each infusion).
- ☐ Alternative Dosage: ______

Physician's Signature: ______ **Date:** ______

Fax completed form to **(503) 540-3105**

Questions? Call us at **(503) 540-9999**

06/20