



Cascade ID & Infusion
Specialty Order Form

Patient: _____	Ordering Provider: _____
DOB: _____ <input type="checkbox"/> M <input type="checkbox"/> 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.

VENOFEER (IRON SUCROSE)

200 mg IV for a total of 5 infusions over 2 weeks (with at least 1 day between each infusion).

Alternative Dosage: _____

Quick Checklist for referring Injectafer and Venofer patients.

- Include demographic sheet and copy of insurance card(s).
- Completed Cascade ID & Infusion Specialty Order Form
- Signed RX
- Recent Progress Note
- Ferritin levels within 30 days

Physician's Signature: _____ Date: _____