Iron Deficiency Anemia Referral F	form				
		ntury Specialty	Script	CENTURY	
			•		
Date:		Fax Referral To: 877-521-5353 Phone: 800-521-3949		SPECIALTY SCRIPT.	
☐ Current Patient ☐ New Patient		Filone. 800-321-3343		/	
Patient Inform	ation		Presc	riber Information	
Patient Name:		Prescribe	Prescriber Name:		
Address:			Address:		
City, State, Zip:					
Home Phone:					
Cell Phone:					
Alternate Phone:			DEA:NPI #:		
DOB: Gender: \square M \square F			Contact Person:		
Insurance Information					
Primary Insurance:				Group:	
Secondary Insurance:					
Prescription Card: ID#:			PCN#:		
rrescription card.				Group.	
Dationt Maight		Medical Information	n		
Patient Weight: Allergies:					
Diagnosis: ☐ D50.9 (Iron Deficiency Anemia)			Secondary ICD-10:		
☐ D50.9 (Iron Deficiency Anemia Sec		(oral iron intolerance or not adequate)			
Dietary Iron Intake)		☐ End-stage Renal Disease			
			_	inal Malabsorption	
□ Chronic Kidney Disease					
☐ Other medical necessity:					
☐ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached					
Recent Labs: CBC, Ferritin, Iron Studies					
Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician					
Lab Orders:			, 5.1 5.1 5.1		
		Medications			
DRIIC	OSE /STRENGTU	Medications	DIDECTIONS		
DRUG D	OSE/STRENGTH		DIRECTIONS	g IV over at least 15 minutes then repeat	
refallente] 510mg/17mL		dose d	ays later	
Ferrlecit	☐ 62.5mg/5mL		☐ Infuse 125mg	g per dialysis session	
Infed] 50mg/mL		☐ Infuse	mL over	
Injectafer	☐ 15mg/kg (<50kg) IV				
	750mg (>/=50kg)	IV	│		
Jadenu	□ 90mg		☐ Take 1 tablet daily		
☐ 180mg					
	360mg				
Monoferric ☐ 20mg/kg (-			☐ One time dose IV		
] 1000mg (>/=50kg	g)	☐ Other:		
Triferic	5.44mg/mL ampu				
	272mg powder		│		
Triferic Avnu	6.75mg		☐ Infuse over 3	-4 hours at each hemodialysis session	
	200mg		☐ Infuse 200mg	g IV weekly x 5 doses	
] 100mg		☐ Infuse 200mg	g IV 5 doses over a 14 day period	
			1	* *	
Prescriber Signature: DAW (Dispense as Written) Date:					