Iron Deficiency Anemia Referral Form

Date: _____

☐ Current Patient ☐ New Patient

Y Medical Associates

Fax Referral To: 855-838-0623

Phone: 800-447-7558

YMedical ASSOCIATES

Patient Information

Patient Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____

Cell Phone: _____

Alternate Phone: _____

DOB: _____ Gender: ☐M ☐ F

Prescriber Information

Prescriber Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Fax: _____

DEA: _____ NPI #: _____

Contact Person: _____

Insurance Information

Primary Insurance: _____ ID#: _____ Group: _____

Secondary Insurance: _____ ID#: _____ Group: _____

Prescription Card: _____ ID#: _____ BIN#: _____ PCN#: _____ Group: _____

Medical Information

Patient Weight: _____ Allergies: _____

Diagnosis:

☐ D50.9 (Iron Deficiency Anemia)

☐ D50.8 (Iron Deficiency Anemia Secondary to Inadequate Dietary Iron Intake)

☐ Other _____

Secondary ICD-10: _____

☐Adverse effect of other drug *(oral iron intolerance or not adequate)*

☐ End-stage Renal Disease

☐ Intestinal 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: _____

Medications

DRUG	DOSE/STRENGTH	DIRECTIONS
Feraheme	☐ 510mg/17mL	☐ Infuse 510mg IV over at least 15 minutes then repeat dose _____ days later
Ferrlecit	☐ 62.5mg/5mL	☐ Infuse 125mg per dialysis session
Infed	☐ 50mg/mL	☐ Infuse _____ mL over _____
Injectafer	☐ 15mg/kg (<50kg) IV ☐ 750mg (>/=50kg) IV	☐ _____
Jadenu	☐ 90mg ☐ 180mg ☐ 360mg	☐ Take 1 tablet daily
Monoferric	☐ 20mg/kg (<50kg) ☐ 1000mg (>/=50kg)	☐ One time dose IV ☐ Other: _____
Triferic	☐ 5.44mg/mL ampules ☐ 272mg powder	☐ _____
Triferic Avnu	☐ 6.75mg	☐ Infuse over 3-4 hours at each hemodialysis session
Venofer	☐ 200mg ☐ 100mg	☐ Infuse 200mg IV weekly x 5 doses ☐ Infuse 200mg IV 5 doses over a 14 day period

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

If Y Medical is the patient's choice for Home or On-Site Infusion Services, please Call, Fax, Mail or send an Electronic Prescription to Y Medical 8840 N MacArthur Blvd Irving, TX 75063 ● Phone (800) 447-7558, Fax (855) 838-0623